# Pediatric Heart Transplant Study
# Form 10r: Death

ID# P | | | | | | | | | | |

| P | Institution Code | Sequential Patient Number | Patient Initials |
|---|---|---|---|

**Complete for <u>all</u> patients listed for transplantation at your institution. Note that some causes of death cannot apply to patients that die awaiting initial transplantation**

Date of Death (mon-day-yr): | | - | | - | |

**1. Primary Cause of Death (check only one):**

- ❑ Early graft failure (≤ 30 days post transplant)
- ❑ Pulmonary Hypertension/RV Failure
- ❑ Rejection, hyperacute (onset < 24 hrs post transplant)
- ❑ Rejection, acute (complete from 05)
- ❑ Coronary artery disease, (infarction, arrhythmia,CHF)
- ❑ Sudden cardiac death, no MI documented
- ❑ Non-specific graft failure (> 30 days post transplant)
- ❑ Malignancy, non-lymphoma (complete form 08)
- ❑ Lymphoma/Lymphoproliferative disease (complete form 08)
- ❑ Pulmonary embolism
- ❑ Infection (complete form 06)
- ❑ Accidental, specify:_____
- ❑ Suicide
- ❑ Unknown
- ❑ Other, specify:_____

**2. Contributing Cause(s) of Death (check all that apply):**

- ❑ Early graft failure (≤ 30 days post transplant)
- ❑ Pulmonary Hypertension/RV Failure
- ❑ Rejection, hyperacute (onset < 24 hrs post transplant)
- ❑ Rejection, acute (complete from 05)
- ❑ Coronary artery disease, (infarction, arrhythmia,CHF)
- ❑ Sudden cardiac death, no MI documented
- ❑ Non-specific graft failure (> 30 days post transplant)
- ❑ Malignancy, non-lymphoma (complete form 08)
- ❑ Lymphoma/Lymphoproliferative disease (complete form 08)
- ❑ Pulmonary embolism
- ❑ Infection (complete form 06)
- ❑ Accidental, specify:_____
- ❑ Suicide
- ❑ Unknown
- ❑ Other, specify:_____

**3a.** Patient listed for re-transplantation prior to death? ❑ No ❑ Yes: **3b.**Date ReListed: __ __-__ __-__ __

**3c.** Patient supported by VAD or TAH at time of death? ❑ No ❑ Yes

**4.** If relisted prior to death: Status **at ReListing**: (Check all that apply for each status)

❑ STATUS 1: → ❑ I.V. Inotropes ❑ IABP ❑ VAD(specify type_____ ❑R ❑L) ❑ TAH ❑ Ventilator ❑ ECMO ❑ PGE dependant ❑ Infant (< 6 months of age)

❑ STATUS 2: → ❑ In Hospital ❑ Out of Hospital ❑ On IV Inotropes **❑ Not relisted prior to death**

**5.** If relisted prior to death: Status **at Death**: (Check all that apply for each status)

❑ STATUS 1: → ❑ I.V. Inotropes ❑ IABP ❑ VAD(specify type_____ ❑R ❑L) ❑ TAH ❑ Ventilator ❑ ECMO ❑ PGE dependant ❑ Infant (< 6 months of age)

❑ STATUS 2: → ❑ In Hospital ❑ Out of Hospital ❑ On IV Inotropes **❑ Inactive (7) or off list.**

**6. Post Mortem Examination (autopsy)? ❑ Yes ❑ No**

If yes: cardiac allograft pathology found (check all that apply):

- ❑ Acute rejection: (ISHLT Grade:_____)
- ❑ CAD, < 50 % stenoses, if so, no vessels___
- ❑ CAD, 75% - < 100% stenosis, if so, no. vessels:___
- ❑ CAD, remote infarction (>1 wk)
- ❑ Other, specify:_____
- ❑ Diffuse fibrosis, no acute rejection
- ❑ CAD, 50% - < 75% stenosis, if so, no. vessels:___
- ❑ CAD, 100% max stenosis, if so no. vessels:____
- ❑ Coronary artery diesease, recent infarction (≤ 1 wk)

**7. Comments or special circumstances surrounding death:**

Person Completing this form:_____

Date Original Form Mailed (do not send copy):_____

PRINT IN BLACK INK ONLY: USE THIS FORM FOR ALL PATIENTS OR EVENTS FROM JULY 1, 1993.

8/1/96 RCB