

Pediatric Heart Transplant Study Form 11⁹⁹: Re-Transplantation

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|--------------|---------|---------|---------|
| ID# P | □ □ □ □ | □ □ □ □ | □ □ □ □ |
|--------------|---------|---------|---------|

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

**Complete for all patients re-transplanted at your institution that were entered into the PHTS, CTRD or TCRD.
Please use the same PHTS number as on the initial Form 01. Complete new forms 1T, 02 & 03.**

| | | |
|--|-------------------------|-------------------------|
| Date of Re-transplantation (mon-day-yr): □ □ □ □ - □ □ □ □ - □ □ □ □ | Height _____ in / cm | Weight _____ lb / kg |
|--|-------------------------|-------------------------|

1. Primary Reason for Re-transplantation (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 post MI)
- Sudden cardiac death, no MI documented
- Non-specific graft failure (> 30 days post transplant)
- Other, specify: _____

2. Contributing Reason(s) for Re-transplantation (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 post MI)
- Sudden cardiac death, no MI documented
- Non-specific graft failure (> 30 days post transplant)
- Other, specify: _____

| | |
|--|---|
| 3. Type of Re-Transplant: <input type="checkbox"/> Orthotopic <input type="checkbox"/> Heterotopic | 3b. Date of ReListing: ____ - ____ - ____ |
|--|---|

4. Status At Listing: 1 1A 1B 2 Other, Specify: _____ (verify status with OPO)

Check All Status Details That Apply Per UNOS Policy 3.7:

- Status 1A, life expect < 7days (UNOS Policy 3.7.4.f)
- In Hospital Out Hospital ICU IV Inotropes, high IV Inotropes, low Hemo Monitoring Ventilator IABP ECMO
- <6 mon old, pulmonary hypertension >50% systemic pressure <6 mon old, pulmonary hyperten <50% systemic pressure
- Growth Failure due to acquired or congenital heart disease
- VAD/TAH: Details: Date 1st Placed: ____ - ____ - ____ VAD > 30 Days with complication, specify: _____
Type: Right Left, Both, TAH Brand/Model: _____

5. Status At Transplant: 1 1A 1B 2 Other, Specify: ____ (verify status with OPO)

Check All Status Details That Apply Per UNOS Policy 3.7:

- Status 1A, life expect < 7days (UNOS Policy 3.7.4.f)
- In Hospital Out Hospital ICU IV Inotropes, high IV Inotropes, low Hemo Monitoring Ventilator IABP ECMO
- <6 mon old, pulmonary hypertension >50% systemic pressure <6 mon old, pulmonary hyperten <50% systemic pressure
- Growth Failure due to acquired or congenital heart disease
- VAD/TAH: Details: Date 1st Placed: ____ - ____ - ____ VAD > 30 Days with complication, specify: _____
Type: Right Left, Both, TAH Brand/Model: _____

6. Explanted organ pathology?: Yes No

- If performed: cardiac allograft pathology found (check all that apply): No Cardiac Pathology Found
- Acute rejection: (ISHLT Grade: _____) Diffuse fibrosis, no acute rejection
 - CAD, < 50 % stenoses, if so, no. vessels: _____ CAD, 50% - < 75% stenosis, if so, no. vessels: _____
 - CAD, 75% - < 100% stenosis, if so, no. vessels: _____ CAD, 100% max stenosis, if so no. vessels: _____
 - CAD, remote infarction (>1 wk) Coronary artery disease, recent infarction (< 1 wk)
 - Other, specify: _____

7 Comments or special circumstances regarding re-transplantation:

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 January 1, 1999.