PEDIATRIC HEART TRANSPLANT STUDY

FORM 11: 2010: **Re-Transplantation** (PG 1 of 1)
To be filled out post-transplant

ID# **P** ☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐

P	Institutional Code	Sequential Patient Number	Patient Initials	Tran #

COMPLETE FORMS 1T, 02, AND 03 FOR RE-TRANSPLANT. DO NOT COMPLETE FORM 01 FOR RE-TRANSPLANTATION.

1. Date of Re-Transplantation: ☐☐ ☐☐ ☐☐
(MO | DAY | YR)

2. Primary Reason for Re-Transplantation (check only one)**:**

- ☐ Coronary artery disease, (infarction, arrhythmia, CHF post MI)
- ☐ Non-specific graft failure (>30 days post transplant)
- ☐ Pulmonary Hypertension/RV Failure
- ☐ Rejection, acute (complete Form 05)
- ☐ Rejection, hyperacute (onset < 24 hours post transplant)
- ☐ Sudden cardiac death, no MI documented
- ☐ Other, specify: _____

3. Contributing Reasons for Re-Transplantation (check all that apply)**:**

- ☐ Coronary artery disease, (infarction, arrhythmia, CHF post MI)
- ☐ Non-compliance
- ☐ Non-specific graft failure (> 30 days post transplant)
- ☐ Pulmonary Hypertension/RV Failure
- ☐ Rejection, acute (complete Form 05)
- ☐ Rejection, hyperacute (onset < 24 hours post transplant)
- ☐ Sudden cardiac death, no MI documented
- ☐ Other, specify: _____

4. Date of Re-Listing: ___ ___ ___

5. Status at Re-Listing:

☐ US ☐ 1A ☐ 1B ☐ 2
☐ Other _____
☐ Canada _____
☐ UK _____
☐ Other _____
ABO incompatible: ☐ No ☐ Yes

Check All Status Details That Apply Per UNOS Policy 3.7 on 11/17/2009:

- ☐ Status 1A, life expect <14 days
- ☐ In Hospital
- ☐ Out Hospital
- ☐ ICU
- ☐ IV Inotropes, high
- ☐ IV Inotropes, low
- ☐ Hemo Monitoring
- ☐ Ventilator
- ☐ <6 mon old, pulmonary hypertension >50% systemic pressure
- ☐ <6 mon old, pulmonary hypertension <50% systemic pressure
- ☐ Growth failure due to acquired or congenital heart disease

If IABP VAD ECMO TAH, complete Mechanical Support Form (Form 15)

6. Pathology of Explanted Heart: ☐ No ☐ Yes If yes: cardiac allograft pathology found (check all that apply):

- ☐ Acute rejection: (ACR: _____, AMR: _____)
- ☐ CAD, remote infarction (>1wk)
- ☐ Coronary artery disease, recent infarction (≤ 1 wk)
- ☐ No cardiac pathology found
- ☐ Diffuse fibrosis, no acute rejection
- ☐ Graft atherosclerosis
- ☐ 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 AFTER JANUARY 1, 2010