

Pediatric Heart Transplant Study Form 11: Re-Transplantation

ID# P	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
P	Institution Code	Sequential Patient Number	Patient Initials		

**Complete for all patients re-transplanted at your institution that were entered into the PHTS.
Please use the same PHTS number as on initial PHTS Form 01.**

Date of Re-transplantation (mon-day-yr):

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: Orthotopic Heterotopic

4a. Status at Re-Listing: (Check all that apply for each status) **4b. Date of ReListing:** ____ - ____ - ____

- 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

5. Status at ReTransplantation: (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

6. Explanted organ pathology ?: Yes No

- Cardiac allograft pathology found (check all that apply):
- Acute rejection: (ISHLT Grade: _____)
 - CAD, < 50 % stenoses, if so, no vessels _____
 - CAD, 50% - < 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 disease, recent infarction (< 1 wk)

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, 1993. 11/12/93 LJB