Pediatric Heart Transplant Study

Form 1T: Transplant Information

P	Institution Code	Sequential Patient Number	Patient Initials

4. Date ofTx: ☐☐ ☐☐ ☐☐

7a. Type of Transplant: ☐ Orthotopic ☐ Heterotopic

7b. At Transplant: Height:____ in/cm Weight:____ lb/kg

Status at Transplant: (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

17a. Donor Specific Crossmatch: ☐ Negative ☐ Positive ☐ Not Done **17b. Influenced Transplant:** ☐ Yes ☐ No

18. Percent Reactive Antibody (closest to transplant):

18a. Cytotoxic PRA: ____% T ____% B ____% Date: ____-____-____ ☐ Not Done
18b. Cytotoxic PRA, DTE/DTT: ____% T ____% B ____% Date: ____-____-____ ☐ Not Done
18c. Flow Cytometry PRA: ____% T ____% B ____% Date: ____-____-____ ☐ Not Done
18d. Other PRA,:_____ ____% T ____% B ____% Date: ____-____-____ ☐ Not Done

20. Immunizations given within 1 month of transplant:
☐ DPT ☐ IPV ☐ HIB ☐ Varicella ☐ Influenza ☐ OPV ☐ MMR ☐HepB ☐Pneumococcal

21c. Labs Closest to Transplant: Creatinine: _____ ☐mg/dl ☐IU/L
BUN: _____ ☐mg/dl ☐IU/L

25. Hemodynamics (at transplant, if repeated since listing):

	Initial	Best
RAm		
PAs		
PAd		
PAm		
PCW		
C.O.		
C.I.		
H.R.		
Aos		
Aod		
Aom		
Qp/Qs		
Rp		
Rs		
Date:	__-__-__	__-__-__

☐ No new data since listing.

Height: _____ in/cm
Weight:_____ lb/kg

Indicate agents for best hemodynamics:
☐ 100% O2
☐ Dopamine
☐ Dobutamine
☐ Isuproterenol (Isuprel)
☐ PGE
☐ Nitroglycerine
☐ Nitroprusside (Nipride)
☐ Others, specify:
_____
_____

26. Restriction at Interatrial Foramen:
(for Hypoplastic Left Heart)
☐ Yes ☐ No Date Dx: ☐☐ ☐☐ ☐☐
☐ < 3mm IA foramen (2d or color)
☐ Restriction confirmed/dx at transplant
☐ Doppler Vel: ___m/sec across foramen
☐ IA Foramen Surgery ☐☐ ☐☐ ☐☐
Catheter Interventions:
☐ Ductal Stent: ☐☐ ☐☐ ☐☐
☐ Septostomy ☐☐ ☐☐ ☐☐
☐ Balloon Dil. of IAS ☐☐ ☐☐ ☐☐

27. Recipient on Inotropes/Pressors at time of transplant? ☐ Yes ☐ No
If yes, please specify with doses:

AGENTS:	Dose/Units	AGENTS:	Dose/Units

28. Transplant Number at Your Institution (sequential number from start of your program): _____

Person Completing this form:

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