Pediatric Heart Transplant Study
Form 1T: Transplant Information

ID# P [ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ]

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

13. 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

18b.PRA* (closest to tx): ____% T ____% B ____% Date: ____-____-____

PRA* (after DTE/DTT): ____% T ____% B ____% Date: ____-____-____

* PRA= panel or percent reactive antibody;
DTE/DTT = treated with IgM reduction agent

19b. 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):_____

PRINT IN BLACK INK ONLY: USE THIS FORM FOR A PATIENTS OR EVENTS AFTER JANUARY 1, 1993.

10/25/93 KJB