

PEDIATRIC HEART TRANSPLANT STUDY

FORM 02: 2010: Donor (PG 1 of 1)

To be filled out at time of transplant

ID# P									
P	Institutional Code	Sequential Patient Number	Patient Initials	Tran #					

1. Donor Age: DAYS MON YRS Donor Date of Birth: (MO | DAY | YR) 2. Gender: Male Female

3a. Donor Race: (See Manual, check all that apply)

<input type="checkbox"/> White	<input type="checkbox"/> Indian Subcontinent
<input type="checkbox"/> Black	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> American Indian/Alaskan Native	
<input type="checkbox"/> Asian	3b. Hispanic Origin:
<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Yes
<input type="checkbox"/> Mid-east/Arabian	<input type="checkbox"/> No

4. Donor Height: _____ in cm

5. Donor Weight: _____ lb kg

6a. Cause of Death: (Check one) Date of event: _____ <input type="checkbox"/> Anoxia <input type="checkbox"/> Cerebrovascular <input type="checkbox"/> CNS Tumor <input type="checkbox"/> Head Trauma <input type="checkbox"/> Other, specify: _____	6b. Mechanism of Death: (Check one) <input type="checkbox"/> Asphyxiation <input type="checkbox"/> Blunt Injury <input type="checkbox"/> Cardiovascular <input type="checkbox"/> CNS Infection <input type="checkbox"/> Drowning <input type="checkbox"/> Drug Intoxication <input type="checkbox"/> Electrical <input type="checkbox"/> Gunshot Wound <input type="checkbox"/> Seizure <input type="checkbox"/> Stab <input type="checkbox"/> Sudden Infant Death <input type="checkbox"/> Other, specify: _____	6c. Circumstances of Death: (Check one) <input type="checkbox"/> Alleged Child Abuse <input type="checkbox"/> Alleged Homicide <input type="checkbox"/> Alleged Suicide <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Non-Motor Vehicle Accident <input type="checkbox"/> Other, specify: _____
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7a. Chest Compressions: (CPR) Yes No CPR Time: _____ minutes 7b. Downtime: _____ minutes

8. Donor Blood Type: A (If known: A1 A2) B AB O 9. Rh: Pos Neg

10. Donor HLA Allotype: <input type="checkbox"/> NA	A	A	B	B	DR	DR
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11. Donor Past Medical History: (Check all that are known)

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Infection, specify: _____
<input type="checkbox"/> Diabetes: If so, on insulin <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> History of Cancer: specify type/location: _____
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Cancer at time of procurement, location: _____

12. Pre-Transplant Donor Echocardiogram: Yes No (If yes, complete section below, check all that apply)

<input type="checkbox"/> Normal	<input type="checkbox"/> Diffuse Wall Motion Abnormality	<input type="checkbox"/> Tricuspid Regurgitation (> mild)
<input type="checkbox"/> Abnormal	<input type="checkbox"/> Focal Wall Motion Abnormality(s)	<input type="checkbox"/> Fractional Shortening: _____% <input type="checkbox"/> NA
<input type="checkbox"/> Abnormal Septal Motion	<input type="checkbox"/> Mitral Regurgitation (> mild)	<input type="checkbox"/> Estimated LV Eject Fraction: _____% <input type="checkbox"/> NA

13. Pre-Transplant Angiogram: Yes No **If yes, specify:** Normal Abnormal
If abnormal, specify: _____

14. Donor Serologies	GENERAL	HIV: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	EBV IgG: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	HEPATITIS	HBs Ag: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA
		CMV IgG: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	RPR: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA		HB core Ab: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA
		IFA Toxo: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA			HBs Ab: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA
					Hep C Ab: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA

15. Cardioplegia/Myocardial Protection (donor):
 Belzer Univ of Wisconsin Collins Roes Celsior Stanford Other, specify: _____

16. Donor on Inotropes, Pressors, or Thyroid Hormones at time of recovery/harvest?

16a. T3 <input type="checkbox"/> Yes <input type="checkbox"/> No	16f. Vasopressin <input type="checkbox"/> Yes <input type="checkbox"/> No	16i. Neosynephrine <input type="checkbox"/> Yes <input type="checkbox"/> No
16b. T4 <input type="checkbox"/> Yes <input type="checkbox"/> No	16g. Levophed <input type="checkbox"/> Yes <input type="checkbox"/> No	16j. Other _____
16c. EPI <input type="checkbox"/> Yes <input type="checkbox"/> No	16h. Milrinone <input type="checkbox"/> Yes <input type="checkbox"/> No	
16d. Dopamine: <input type="checkbox"/> None <input type="checkbox"/> < 10 mcg <input type="checkbox"/> 10-20 mcg <input type="checkbox"/> > 20 mcg <input type="checkbox"/> Unknown		
16e. Dobutamine: <input type="checkbox"/> None <input type="checkbox"/> < 10 mcg <input type="checkbox"/> 10-20 mcg <input type="checkbox"/> > 20 mcg <input type="checkbox"/> Unknown		

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