# Pediatric Heart Transplant Study
## Form 0399: Initial Immunosuppression & Antibiotics

ID# P | | | | | | | | | | |

| P | Institution Code | Sequential Patient Number | Patient Initials |
|---|---|---|---|

## A. Initial Immunosuppression: (complete and mail 30 days post transplant)

**1. Induction Therapy (cytolytic therapy soon after transplant not used to specifically treat known rejection)**

❑ **Yes (if yes complete this question)** ❑ **No (if no, skip to number 2)**

**Specifics of Induction; indicate any dose or agent change on a new line:**

| AGENT* | Pre-Op Dose? | Intra-Op Dose? | Dose/Day & units | Start Date | Stop Date |
|---|---|---|---|---|---|
| | ❑ Yes ❑ No | ❑ Yes ❑ No | | __ __-__ __-__ __ | __ __-__ __-__ __ |
| | ❑ Yes ❑ No | ❑ Yes ❑ No | | __ __-__ __-__ __ | __ __-__ __-__ __ |
| | ❑ Yes ❑ No | ❑ Yes ❑ No | | __ __-__ __-__ __ | __ __-__ __-__ __ |
| | ❑ Yes ❑ No | ❑ Yes ❑ No | | __ __-__ __-__ __ | __ __-__ __-__ __ |

***Induction Agents:**
**OKT3**
**ALG**
**ATG.**

**If other, please specify.**

**2a. Cyclosporine:** -Pre-Op Dose ❑ Yes ❑ No (if yes, specify: _____ mg ❑ PO ❑ IV)
--Date First Post Op Cyclosporine Dose: __ __ - __ __ - __ __. Dose _____ mg, ❑ PO ❑ IV
--Brand: ❑ Sandimmune ❑ Neoral ❑ Generic/Other/Study, specify: _____
--Date First Post Op Oral/NGtube Dose (if initial post op dose given IV): __ __ - __ __ - __ __

**2b. Tacrolimus (Prograf, FK-506)**: --Pre-Op Dose: ❑ Yes ❑ No (if yes, specify: _____ mg ❑ PO ❑ IV)
--Date First Post Op tacrolimus dose: __ __ - __ __ - __ __. Dose: _____ mg (❑ PO ❑ IV)

**3a. Azathioprine (Imuran):** --Pre-Op Dose: ❑ Yes ❑ No (if yes, specify: _____ mg ❑ PO ❑ IV)
--Date First Post Op azathioprine dose: __ __ - __ __ - __ __. Dose: _____ mg (❑ PO ❑ IV)

**3b. Mycophenolate (Cellcept):** --Pre-Op Dose: ❑ Yes ❑ No (if yes, specify: _____ mg ❑ PO ❑ IV)
--Date First Post Op mycophenolate dose: __ __ - __ __ - __ __. Dose: _____ mg (❑ PO ❑ IV)

**4. Steroids:** Pre-Op: ❑ None ❑ Prednisone ❑ Prednisolone ❑ Solumedrol: ____ mg ❑ PO ❑ IV
Intra-Op: ❑ None ❑ Solumedrol: ____ mg IV ❑ Other, specify: _____ dose: _____
Post-Op: Start Date: ___ ___ - ___ ___ - ___ ___ (first post op dose)
Initial Dose: _____mg ❑ PO ❑ IV (total dose that day) Type: ❑Prednisone ❑Prednisolone ❑ Solumedrol
At 14 Days: _____mg ❑ PO ❑ IV (total dose per day) Type: ❑Prednisone ❑Prednisolone ❑ Solumedrol
At 30 Days: _____mg ❑ PO ❑ IV (total dose per day) Type: ❑Prednisone ❑Prednisolone ❑ Solumedrol

**6. Other immunosuppression** (specify:_____):
a. Pre-Op Dose ❑ Yes ❑ No If yes, specify: _____ mg ❑ PO ❑ IV ❑ Blinded dose per protocol.
b. Date First Post Op Dose (if any): __ __ - __ __ - __ __. Dose: ____ mg, ❑ PO ❑ IV ❑ Blinded dose per protocol

**7. List and describe any unusual pre-op or early (1st 30 days) immunosuppression or procedures (including plasmapheresis, photopheresis, immunoabsorption, or radiation (TLI)) with dates:**

_____
_____
_____
_____
_____

## B. Prophylactic Antibiotics/Antivirals started Pre-op through 30 days post op:

**8. Infection Prophylaxis** started during first 30 days post transplant (not used to treat a known infection):

| | | |
|---|---|---|
| ❑ Ganciclovir (Cytovene) | Date Start: __ __ - __ __ - __ __ | Days of Therapy Intended: _____ |
| ❑ Acyclovir (Zovirax) | Date Start: __ __ - __ __ - __ __ | Days of Therapy Intended: _____ |
| ❑ Trimethoprim/sulfa | Date Start: __ __ - __ __ - __ __ | Days of Therapy Intended: _____ |
| ❑ Antifungal (specify:_____) | Date Start: __ __ - __ __ - __ __ | Days of Therapy Intended: _____ |
| ❑ Other (specify:_____) | Date Start: __ __ - __ __ - __ __ | Days of Therapy Intended: _____ |
| ❑ Immune Globulin | Date Start: __ __ - __ __ - __ __ | Days of Therapy Intended: _____ |
| ❑ Other,specify: _____) | Date Start: __ __ - __ __ - __ __ | Days of Therapy Intended: _____ |

❑ Peri-operative* antibiotics: Specify:_____

* Peri-operative includes: pre-operative, intra-operative, and started prophylactically immediately post-operative.

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, 1999.

2/14/99 RCB