

# PEDIATRIC HEART TRANSPLANT STUDY

FORM 03: 2010: Initial Immunosuppression & Antibiotics (PG 1 of 1)

To be filled out 30 days post-transplant

ID# P

P

Institutional Code

Sequential Patient Number

Patient Initials

Tran #

## A. Initial Immunosuppression

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

No (If no, skip to # 2)  Yes (If yes, complete this section)

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

AGENT\*

Start Date

Stop Date

\*Induction Agents:

ALG

ATG

Simulect (Basiliximab)

Zenapax (Daclizumab)

If other, please specify.

\_\_\_\_\_

MO DAY YR

MO DAY YR

\_\_\_\_\_

MO DAY YR

MO DAY YR

\_\_\_\_\_

MO DAY YR

MO DAY YR

\_\_\_\_\_

MO DAY YR

MO DAY YR

### 2. Azathioprine (Imuran):

Yes  No

Daily dose at

If yes, date of first post-op dose: \_\_\_\_

\_\_\_\_

30 days post transplant \_\_\_\_\_ mg/per day

PO  IV

### 3. Cyclosporine:

Yes  No

Daily dose at

If yes, date of first post-op dose: \_\_\_\_

\_\_\_\_

30 days post transplant \_\_\_\_\_ mg/per day

PO  IV

### 4. Mycophenolate (Cellcept, Myfortic):

Yes  No

Daily dose at

If yes, date of first post-op dose: \_\_\_\_

\_\_\_\_

30 days post transplant \_\_\_\_\_ mg/per day

PO  IV

### 5. Sirolimus (Rapamycin):

Yes  No

Daily dose at

If yes, date of first post-op dose: \_\_\_\_

\_\_\_\_

30 days post transplant \_\_\_\_\_ mg/per day

PO  IV

### 6. Tacrolimus (Prograf, FK506):

Yes  No

Daily dose at

If yes, date of first post-op dose: \_\_\_\_

\_\_\_\_

30 days post transplant \_\_\_\_\_ mg/per day

PO  IV

### 7. Sterioids:

Pre-Operative  Yes  No

Intra-Operative  Yes  No

Post-Operative: Start Date: \_\_\_\_ (first post op dose)

Daily dose at 30 days \_\_\_\_\_ mg  PO  IV

Type at 30 days:  Prednisone  Prednisolone  Solumedrol

Maintenance Sterioids:

Yes  No If no, end date of steroid use \_\_\_\_

### 8. Other Immunosuppressants:

Yes  No

If yes, specify: \_\_\_\_\_

If yes, date of first post op dose: \_\_\_\_

### 9. List and describe any unusual pre-op or early (1st 30 days) immunosuppression or procedures (including

plasmapheresis, photopheresis, immunoabsorption, or radiation (TLI) with dates): Desensitization strategies or anti-HLA therapies should be reported on Form 16: Anti-HLA Antibody.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

### 10. Infection Prophylaxis: Started during first 30 days post transplant (not used to treat a known infection):

Acyclovir (Zovirax)

Immune Globulin

Antifungal therapy, specify: \_\_\_\_\_

Trimethoprim | Sulfa

Cytogam

Other, specify: \_\_\_\_\_

Ganciclovir or Valganciclovir

### 11. Date of Hospital Discharge: \_\_\_\_

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