

# Pediatric Heart Transplant Study

## Form 05r: Rejection

ID# P

P Institution Code       Sequential Patient Number       Patient Initials

1. Baseline Immunosuppressive Therapy at Time of Rejection\*: Weight: \_\_\_\_\_  lbs  kg

\* If drug is not given daily (other than methotrexate), list dose averaged per day (e.g. 150mg azathioprine QOD = 75 mg/day).

Prednisone: \_\_\_\_\_  mg/day  mg/kg/day Labs at time of rejection if on indicated drug: \_\_\_\_\_

Azathioprine: \_\_\_\_\_  mg/day  mg/kg/day Total WBC: \_\_\_\_\_

Cyclosporine:  Sandimmune  Neoral \_\_\_\_\_  mg/day  mg/kg/day Trough level: \_\_\_\_\_ Method of level: \_\_\_\_\_

Tacrolimus (FK506): \_\_\_\_\_  mg/day  mg/kg/day Trough level: \_\_\_\_\_ Method of level: \_\_\_\_\_

Methotrexate \_\_\_\_\_  mg/week  mg/kg/week Total WBC: \_\_\_\_\_

Mycophenolate \_\_\_\_\_  mg/day  mg/kg/day Total Lymphocytes: \_\_\_\_\_ (WBC x % lymphocytes)

Other (specify with dose): \_\_\_\_\_  mg/kg  mg/kg/day  other (specify): \_\_\_\_\_

2. Additional Immunosuppressive Therapy Since Last Rejection or Transplant:

Total Lymphoid Irrad: Total Dose: \_\_\_\_\_ cGy  Plasmapheresis  Photopheresis  Other, specify: \_\_\_\_\_

3. Biopsy prior to date of rejection diagnosis:  Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Biopsy Score: \_\_\_\_\_  None performed

4. REJECTION: Start form with a newly diagnosed rejection by biopsy (convert to ISHLT score) or other criteria leading to bolus immunotherapy. List all follow-up biopsies or changes in therapy. The last entry should be first biopsy or echo not prompting additional therapy. Please list therapies per the following choice codes: (see instructions for prednisone taper):

- 1 = Steroids, Intravenous      4 = ATG      6 = Prednisone taper\*: \_\_\_\_\_
- 2 = Steroids, Oral              5 = ALG      \*see instruction manual for description of Prednisone taper coding instructions.
- 3 = OKT3                              7 = Other (specify): \_\_\_\_\_
- N = First biopsy without rejection requiring additional treatment

Date of Diagnosis, Start of New Therapy Change in Therapy, & all Biopsies until no bolus therapy added.	Basis for Dx: (All that apply)			Biopsy Score*	Therapy for Rejection: (see choice codes above)	Drug Dose per Day (indicate units)	Start Date of Therapy	End Date of Therapy	Hemo-dynamic Compro-mise ?
	Echo	Clinical	Biopsy						
<input type="text"/> <input type="text"/> <input type="text"/> Month      Day      Year	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	1.	1.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> NONE	
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				3.	3.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Inotropic support used	
*convert to ISHLT standard Bx score									
<input type="text"/> <input type="text"/> <input type="text"/> Month      Day      Year	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	1.	1.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> NONE	
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ALL PATIENTS OR EVENT FROM JULY 1, 1996

PRINT IN BLACK INK ONLY: USE THIS FORM I

8/1/96 RCB

Person Completing this form \_\_\_\_\_

Date Original Form Mailed (do not FAX): \_\_\_\_\_