

Pediatric Heart Transplant Study

Form 0599: 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 Gen _____ 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: _____ mg/day mg/kg/day mg/wk

Other, specify: _____ mg/day mg/kg/day mg/wk

Other, specify: _____ mg/day mg/kg/day mg/wk

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, IV **5** = ALG **N**=First biopsy without rejection requiring additional treatment
2 = Steroids, Oral **6** = Steroid taper: list end dose under Therapy column. *see instruction manual for description of Prednisone taper coding instructions.
3 = OKT3 **7** = Other, specify: _____
4 = ATG **8** = Other, specify: _____

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) (also end steroid taper dose)	Drug Dose per Day or Start dose for taper (choice 6) (indicate units)	Start Date of Therapy	End Date of Therapy	Hemodynamic Compromise ?	
	Echo	Clinical	Biopsy							
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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="checkbox"/> NONE
				2.	2.	-	-	-	-	<input type="checkbox"/> Mild
				3.	3.	-	-	-	-	<input type="checkbox"/> Inotropic support used
				4.	4.	-	-	-	-	
*convert to ISHLT standard Bx score										
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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="checkbox"/> NONE
				2.	2.	-	-	-	-	<input type="checkbox"/> Mild
				3.	3.	-	-	-	-	<input type="checkbox"/> Inotropic support used
				4.	4.	-	-	-	-	
*convert to ISHLT standard Bx score										
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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="checkbox"/> NONE
				2.	2.	-	-	-	-	<input type="checkbox"/> Mild
				3.	3.	-	-	-	-	<input type="checkbox"/> Inotropic support used
				4.	4.	-	-	-	-	
*convert to ISHLT standard Bx score										
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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="checkbox"/> NONE
				2.	2.	-	-	-	-	<input type="checkbox"/> Mild
				3.	3.	-	-	-	-	<input type="checkbox"/> Inotropic support used
				4.	4.	-	-	-	-	
*convert to ISHLT standard Bx score										

Person Completing this form: _____ Date Original Form Mailed (do not FAX): _____

PRINT IN BLACK INK ONLY: USE THIS FORM FOR ALL PATIENTS OR EVENT FROM January 1, 1999. 2/14/99 RCB