PRINT IN BLACK INK ONLY: USE THIS FORM FOR ALL PATIENTS OR EVENTS AFTER JANUARY 1 2005

Pediatric Heart Transplant Study

FORM 05₀₅: Rejection (Page 1 of 1)

ID# P			
P	Institution Code	Sequential Patient Number	Patient Initials

1. Weight at Time of Rejection: ________ ☐ lb ☐ kg

2. Baseline Immunosuppressive Therapy at Time of Rejection*:
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		
Azathioprine (Imuran):	_______ mg/day		
Cyclosporine: ☐Sandimune ☐ Other ☐Neoral ☐gengraf	_______ mg/day	Trough level: ____________	Method of level: ________________
Tacrolimus (Prograf, FK506):	_______ mg/day	Trough level: ____________	Method of level: ________________
Methotrexate:	_______ mg/day		
Mycophenolate (Cellcept):	_______ mg/day		
Sirolimus (Rapamycin):	_______ mg/day	Trough level: ____________	
Cytoxan	_______ ☐mg/day ☐mg/wk		
Plasmapheresis	Frequency _______ times per week		
Other, specify:	_______ ☐ mg/day ☐ mg/wk	Other, specify:	_______ ☐ mg/day ☐ mg/wk
Other, specify:	_______ ☐ mg/day ☐ mg/wk	Other, specify:	_______ ☐ mg/day ☐ mg/wk

3. Biopsy prior to date of rejection diagnosis: ☐ Date: __ __ - __ __ - __ __ ISHLT Score: ________ ☐ None performed

4. REJECTION: Start with 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**.**

THERAPY CODES: Please list therapies using the following codes

1 = Steroids, IV
2 = Steroids, Oral
3 = OKT3
4 = ATG
5 = ALG
6 = Steroid taper: list start and end doses
7 = Methotrexate
8 = ATS
9 = Tacrolimus (Prograf, FK506)
10 = Other: ____

***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) Echo	Clinical	Biopsy	Biopsy Score*	Rejection Therapy: (see choice codes above)	Drug Dose or Start dose for Steroid taper (mg/day)	End Dose for Steroid taper (mg/day)	Start Date of Therapy	End Date of Therapy	Hemo-dynamic Compro-mise?
☐☐ ☐☐ ☐☐ Month Day Year	☐	☐	☐		1.	1.		- -	- -	☐ None
					2.	2.		- -	- -	☐ Mild
	*convert to ISHLT standard Bx score				3.	3.		- -	- -	☐ Inotropic support used
					4.	4.		- -	- -	
☐☐ ☐☐ ☐☐ Month Day Year	☐	☐	☐		1.	1.		- -	- -	☐ None
					2.	2.		- -	- -	☐ Mild
	*convert to ISHLT standard Bx score				3.	3.		- -	- -	☐ Inotropic support used
					4.	4.		- -	- -	
☐☐ ☐☐ ☐☐ Month Day Year	☐	☐	☐		1.	1.		- -	- -	☐ None
					2.	2.		- -	- -	☐ Mild
	*convert to ISHLT standard Bx score				3.	3.		- -	- -	☐ Inotropic support used
					4.	4.		- -	- -	
☐☐ ☐☐ ☐☐ Month Day Year	☐	☐	☐		1.	1.		- -	- -	☐ None
					2.	2.		- -	- -	☐ Mild
	*convert to ISHLT standard Bx score				3.	3.		- -	- -	☐ Inotropic support used
					4.	4.		- -	- -	
☐☐ ☐☐ ☐☐ Month Day Year	☐	☐	☐		1.	1.		- -	- -	☐ None
					2.	2.		- -	- -	☐ Mild
	*convert to ISHLT standard Bx score				3.	3.		- -	- -	☐ Inotropic support used
					4.	4.		- -	- -	

Person Completing This Form: ______________________________

Date Original Form Mailed (do not FAX):___________________