PEDIATRIC HEART TRANSPLANT STUDY

FORM 05: 2010: **Rejection** (PG 1 of 2)
To be filled out post-transplant

ID# P

P	Institutional Code	Sequential Patient Number	Patient Initials	Tran #

1. Weight at time of rejection: _________ ☐ lb ☐ kg

2. Baseline immunosuppressive therapy at time of rejection:

- ☐ Prednisone
- ☐ Azathioprine (Imuran)
- ☐ Cyclosporine:
  - ☐ Sandimune ☐ Neoral ☐ Gengraf ☐ Other
- ☐ Tacrolimus (Prograf, FK506)
- ☐ Methotrexate
- ☐ Mycophenolate (Cellcept, Myfortic)
- ☐ Sirolimus (Rapamycin)
- ☐ Cytoxan
- ☐ Plasmapheresis: Frequency: ____________________
- ☐ Rituximab
- ☐ Immune globulin
- ☐ Other, specify: ________________________________
- ☐ Other, specify: ________________________________
- ☐ Other, specify: ________________________________
- ☐ Other, specify: ________________________________

3. Biopsy prior to date of rejection diagnosis: ☐ Not Done
Date: ___ ___ ___ ACR _____ AMR _____

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
4 = ATG
5 = ALG
6 = Steroid taper
7 = Methotrexate
8 = ATS
9 = Tacrolimus (Prograf, FK506)

10 = Other: ____________________________________
11 = Other: ____________________________________
12 = Other: ____________________________________
13 = Other: ____________________________________
14 = Other: ____________________________________
15 = Other: ____________________________________

16 = Rituximab
17 = Plasmapheresis
18 = Photopheresis
19 = Cytoxan
20 = Immune globulin

***N = First biopsy without rejection requiring additional treatment**

Biopsy A. 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		Indication for Biopsy (check one only)				Rejection Therapy: (see choice codes above)	Total Days of Therapy:	Hemo-dynamic Compromise?
	Echo	Clinical	Biopsy	ACR	AMR*	Routine protocol	Obj. Evid. Graft Dys.	Symtoms	Research			
(MO | DAY | YR)	☐	☐	☐			☐	☐	☐	☐	1. ________ 2. ________ 3. ________ 4. ________ 5. ________ 6. ________	________ ________ ________ ________ ________ ________	☐ None ☐ Mild ☐ Inotropic support used
				* if AMR then please complete special studies for antibody medicated rejection								

Special studies for antibody mediated rejection (AMR): (check all that apply)
Are there biopsy features consistent with AMR? ☐ Yes ☐ No
If Yes: ☐ Yes ☐ No Immunoflorescence studies? ☐ Positive ☐ Negative
☐ Yes ☐ No C4D staining? ☐ Positive ☐ Negative

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PEDIATRIC HEART TRANSPLANT STUDY

FORM 05: 2010: **Rejection** (PG 2 of 2)
To be filled out post-transplant

ID# **P** ☐☐☐ ☐☐☐☐ ☐☐☐ ☐

P	Instituitional Code	Sequential Patient Number	Patient Initials	Tran #

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See page 1 for therapy codes

Biopsy B. 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		Indication for Biopsy (check one only)				Rejection Therapy: (see choice codes above)	Total Days of Therapy:	Hemo-dynamic Compromise?
	Echo	Clinical	Biopsy	ACR	AMR*	Routine protocol	Obj. Evid. Graft Dys.	Symtoms	Research			
☐☐ ☐☐ ☐☐ (MO | DAY | YR)	☐	☐	☐		* if AMR then please complete special studies for antibody medicated rejection	☐	☐	☐	☐	1. ________ 2. ________ 3. ________ 4. ________ 5. ________ 6. ________	________ ________ ________ ________ ________ ________	☐ None ☐ Mild ☐ Inotropic support used

Special studies for antibody mediated rejection (AMR): (check all that apply)
Are there biopsy features consistent with AMR? ☐ Yes ☐ No
If Yes: ☐ Yes ☐ No Immunoflorescence studies? ☐ Positive ☐ Negative
☐ Yes ☐ No C4D staining? ☐ Positive ☐ Negative

Biopsy C. 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		Indication for Biopsy (check one only)				Rejection Therapy: (see choice codes above)	Total Days of Therapy:	Hemo-dynamic Compromise?
	Echo	Clinical	Biopsy	ACR	AMR*	Routine protocol	Obj. Evid. Graft Dys.	Symtoms	Research			
☐☐ ☐☐ ☐☐ (MO | DAY | YR)	☐	☐	☐		* if AMR then please complete special studies for antibody medicated rejection	☐	☐	☐	☐	1. ________ 2. ________ 3. ________ 4. ________ 5. ________ 6. ________	________ ________ ________ ________ ________ ________	☐ None ☐ Mild ☐ Inotropic support used

Special studies for antibody mediated rejection (AMR): (check all that apply)
Are there biopsy features consistent with AMR? ☐ Yes ☐ No
If Yes: ☐ Yes ☐ No Immunoflorescence studies? ☐ Positive ☐ Negative
☐ Yes ☐ No C4D staining? ☐ Positive ☐ Negative

Biopsy D. 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		Indication for Biopsy (check one only)				Rejection Therapy: (see choice codes above)	Total Days of Therapy:	Hemo-dynamic Compromise?
	Echo	Clinical	Biopsy	ACR	AMR*	Routine protocol	Obj. Evid. Graft Dys.	Symtoms	Research			
☐☐ ☐☐ ☐☐ (MO | DAY | YR)	☐	☐	☐		* if AMR then please complete special studies for antibody medicated rejection	☐	☐	☐	☐	1. ________ 2. ________ 3. ________ 4. ________ 5. ________ 6. ________	________ ________ ________ ________ ________ ________	☐ None ☐ Mild ☐ Inotropic support used

Special studies for antibody mediated rejection (AMR): (check all that apply)
Are there biopsy features consistent with AMR? ☐ Yes ☐ No
If Yes: ☐ Yes ☐ No Immunoflorescence studies? ☐ Positive ☐ Negative
☐ Yes ☐ No C4D staining? ☐ Positive ☐ Negative

Person completing this form: ________________________________ Date original form mailed (do not send copy) ____________