

Pediatric Heart Transplant Study Form 05: 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 (i.e. 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: _____ mg/day mg/kg/day Trough level: _____ Method: _____

FK506: _____ mg/day mg/kg/day Trough level: _____ Method: _____

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 | Hemodynamic Compromise ? |
|---|-------------------------------------|--------------------------|--------------------------|---------------|---|------------------------------------|---|---|---|
| | Echo | Clinical | Biopsy | | | | | | |
| <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year | <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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> NONE |
| | | | | | 2. | 2. | <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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Mild |
| | | | | | 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="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"/> | | 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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> NONE |
| | | | | | 2. | 2. | <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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Mild |
| | | | | | 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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Inotropic support used |
| <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year | <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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> NONE |
| | | | | | 2. | 2. | <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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Mild |
| | | | | | 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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Inotropic support used |
| <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year | <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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> NONE |
| | | | | | 2. | 2. | <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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Mild |
| | | | | | 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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Inotropic support used |

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, 1993.