PRINT IN BLACK INK ONLY: USE THIS FORM FOR ...L PATIENTS OR EVENTS FROM JULY 1, 1996.

Pediatric Heart Transplant Study
Form 06r: Infection (Page _ of _ for this infection)

ID# P [ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ]

P | Institution Code | Sequential Patient Number | Patient Initials

INFECTION: Evidence of infectious process requiring I.V. therapy or a life threatening infection requiring oral therapy.
PLEASE: Use a separate form for each infection episode and/or type of organism.

1. Date of Infection (mon-day-yr): [ ][ ] - [ ][ ] - [ ][ ]

2. Prophylactic Drug Therapy <u>at time of infection</u>: Indicate if there was an ongoing prophylactic course of each, do not include course given to treat a specific infection (course used to treat infection should be noted under # 5 below).

Prophylactic Drug:	Total Daily Dose/units/route:
❑ Acyclovir	
❑ Timethoprin/sulfa	
❑ Ganciclovir (Cytovene)	
❑ Immune Globulin	
❑ Antifungal,specify:________________	
❑ Other: specify:____________________	
❑ Other, specify:____________________	

3. Type of Infection (check one): (use separate form for each episode and/or type of infection)

❑ **Bacterial** ❑ **Fungal** ❑ **Viral** ❑ **Varicella** ❑ **Protozoan**

Organism(s): ____

____

If CMV: specify 1° means of diagnosis: ❑ Culture positive ❑ Histology ❑ Serology ❑ Clinical criteria alone

4. Location (organ system, mark all that apply to this infection):

❑ GI Tract, specify:____________
❑ Lung/Pleura
❑ Skin
❑ Blood (culture positive)
❑ Urinary Tract
❑ Prostate/Epidydimis
❑ Wound, surgical
❑ Wound, traumatic
❑ Soft tissue
❑ Bone
❑ Heart (endocarditis)
❑ Pericardium
❑ Uterus/Cervix/Tubal
❑ Other(s), specify:____________________
____

5. Therapy (indicate new drug on a new line, use additional pages if needed):

Drug:	Route Given:	Date Started:	Date Ended:
	❑ PO ❑ IV ❑ IM	__ __-__ __-__ __	__ __-__ __-__ __
	❑ PO ❑ IV ❑ IM	__ __-__ __-__ __	__ __-__ __-__ __
	❑ PO ❑ IV ❑ IM	__ __-__ __-__ __	__ __-__ __-__ __
	❑ PO ❑ IV ❑ IM	__ __-__ __-__ __	__ __-__ __-__ __
	❑ PO ❑ IV ❑ IM	__ __-__ __-__ __	__ __-__ __-__ __
	❑ PO ❑ IV ❑ IM	__ __-__ __-__ __	__ __-__ __-__ __
	❑ PO ❑ IV ❑ IM	__ __-__ __-__ __	__ __-__ __-__ __

6. Surgical Intervention(s) ❑ **No** ❑ **Yes: specify:**________________________________

7. Outcome (check one):

❑ **Resolution** ❑ **Death (complete Death form)**
❑ **Significant Long Term Sequellae*, specify:**________________________

* Significant long term sequellae means any residual medical problem persisting for ≥ 30 days after the onset of the infection (e.g. renal failure, respiratory failure, etc.)

Person Completing this form:____________________ Date Original Form Mailed (do not send copy) ____________

8/1/96 RCB