Pediatric Heart Transplant Study

Form 0699: **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 ❑ Protozoan

Organism(s): ____

____ **❑ Varicella**

If CMV: specify 1° means of diagnosis: ❑ Culture positive ❑ Histology ❑ Serology ❑ Antigenemia ❑ 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,

Person Completing this form:__________________________ Date Original Form Mailed (do not send copy):_____________

PRINT IN BLACK INK ONLY: USE THIS FORM FOR ALL PATIENTS OR EVENTS FROM January 1, 1999.

2/14/99 RCB