Pediatric Heart Transplant Study

FORM 06$_{05}$: Infection (Page 1 of 1)

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. Drug Therapy at time of infection: 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).

Drug Therapy at time of infection	
☐ Acyclovir	☐ Mycophenolate
☐ Antifungal	☐ OKT3
☐ ATG	☐ Prednisone
☐ Azathiorpine (Imuran)	☐ Sirolimus (Rapamycin)
☐ Cyclosporine	☐ Tacrolimus (Prograf, FK506)
☐ Ganciclovir or Valganciclovir	☐ Trimethoprim/sulfa
☐ Immune Globulin	☐ Other, specify: ______________________________
☐ Methotrexate	

3a. Type of Infection (check one): (use separate form for each episode and/or type of infection)
☐ Bacterial ☐ Fungal ☐ Viral ☐ Protozoan ☐ Varicella ☐ No organism identified

3b. Type of Organism(s): ____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

3c. If CMV: Specify primary means of diagnosis:
☐ CMV PCR ☐ 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
☐ Wound, surgical
☐ Soft Tissue
☐ Bone
☐ Heart (endocarditis)
☐ Pericardium
☐ 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** **If yes, specify:**______________________________

7. Outcome (check one):
☐ Resolution ☐ Death (complete Death form, Form 10)
☐ 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 AFTER JANUARY 1, 2005