PEDIATRIC HEART TRANSPLANT STUDY

FORM 06: 2010: **Infection** (PG 1 of 1)

To be filled out post-transplant

ID# **P** ___ ___ ___ | ___ ___ ___ ___ | ___ ___ ___ | ___

P	Institutional Code	Sequential Patient Number	Patient Initials	Tran #

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: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

2. 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.)

- ☐ Acyclovir
- ☐ Antifungal
- ☐ ATG
- ☐ Azathioprine (Imuran)
- ☐ Cyclosporine
- ☐ Ganciclovir or Valganciclovir
- ☐ Immune Globulin
- ☐ MMF (Cellcept, Myfortic)
- ☐ Methotrexate
- ☐ Prednisone
- ☐ Rituximab
- ☐ Sirolimus (Rapamycin)
- ☐ Tacrolimus (Prograf, FK506)
- ☐ Trimethoprim/sulfa
- ☐ Other, specify: ______________________________

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 sequelae*, specify: ____

* Significant long term sequelae 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, 2010