Pediatric Heart Transplant Study
Form 06: 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 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).

Prophylactic Drug:	Total Daily Dose/units:
❑ Acyclovir	
❑ Timethoprin/sulfa	
❑ DHPG(ganciclovir)	
❑ Immune Globulin	
❑ Antifungal	
❑ Antifungal (oral-nonabsorbed)	
❑ 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): ______________________________

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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):__________

PRINT IN BLACK INK ONLY: USE THIS FORM FOR PATIENTS OR EVENTS FROM JANUARY 1, 1993.

7/17/93 RC