Pediatric Heart Transplant Study

FORM 08$_{05}$: Post Transplant Yearly Status Report
(Page 1 of 1)

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

P	Institution Code	Sequential Patient Number	Patient Initials

1. Date of Follow-up (mon-day-yr): ☐☐☐☐☐☐

2a. Height __________ ☐ in ☐ cm

2b. Weight __________ ☐ lb ☐ kg

3. Hemodynamics: Date: ___ ___ - ___ ___ - ___ ___ (Mon Day Year)

AoM	RAm	PAm	PCW	C.O.	C.I.

4a. Current Patient Residence (check one below):
☐ Home ☐ Other (specify): ____________________

4b. Current residence ZIP Code/Postal Code __ __ __ __ __ __

5. Patient Medical Care at time of this report: (check either 5a ***OR*** 5b)

5a. ☐ Patient currently followed at our PHTS transplant center (if checked, then check one below indicating degree of care provided at PHTS center):
- ☐ All care is provided at our center (Skip to Question #7)
- ☐ Almost all (most) medical care is provided at our center.
- ☐ Transplant related care (cardiovascular) and/or severe illness care at our center, other care elsewhere.
- ☐ Only yearly evaluation at our center, we do not follow PHTS events
  If only yearly evaluation, specify date PHTS event follow-up ceased ___ ___ - ___ ___ - ___ ___

5b. ☐ Patient followed exclusively at another center: Specify date of last follow-up at your center. ___ ___ - ___ ___ - ___ ___

6. Non PHTS center care at time of this report: Specify reason for any care being provided at another center (if chosen above):
- ☐ Patient desire, not related to location
- ☐ Patient residence location, financial concerns (not due solely to medical care costs)
- ☐ Patient residence location, convenience
- ☐ Care shifted to another center after transpant per contract with 3rd party payer (mandated by contract).
  (if so, date of care shift: __ __ - __ __ - __ __)
- ☐ Other reason(s), specify: ____________________

7. Medications:
- ☐ Antihypertensive
- ☐ Antiviral prophylaxis
- ☐ Azathioprine (Imuran)
- ☐ Cyclosporine
- ☐ Diuretic
- ☐ Methotrexate
- ☐ Mycophenolate
- ☐ Prednisone
- ☐ Sirolimus
- ☐ Statin
- ☐ Tacrolimus
- ☐ Other ____________

8. Schooling
- ☐ Within one grade level
- ☐ Delayed grade level
- ☐ Special education
- ☐ Not applicable, <6 years
- ☐ Status unknown

9. Treadmill Test ☐ Not Done
Resting BP: ____/____
HR: _____
Maximum duration: ______ min
Maximum BP: ____/____
HR: _____
% Predicted for Age: ______

10. Additional Immunosuppresive Therapy: (Since Transplant or last Form 08)
☐ Total Lymphoid Irrad: Total Dose ____ cGy ☐ Plasmapheresis ☐ Photopheresis ☐ Other, specify: __________________

11a. Primary Insurance (check one): Medicaid (☐State ☐HMO) ☐Other Gov ☐Private ☐Self ☐Donation ☐Free ☐Other ____________________

11b. Secondary Insurance (check all that apply): Medicaid (☐State ☐HMO) ☐Other Gov ☐Private ☐Self ☐Donation ☐Free ☐Other ____________________

12. Laboratory: Date Performed, (nearest this report due date): __ __ - __ __ - __ __ (print "NA" in spaces if not done)
Was lipid profile fasting: ☐ Yes ☐ No

Cholesterol	TG	LDL	HDL	VLDL	BUN	Creatinine	T Protein	Serum/Albumin

13. Events: (Since Transplant or last last Form 08)

Event			
Coronary angiography	☐ Yes	☐ No	If yes, complete Form 04
Rejection	☐ Yes	☐ No	If yes, complete Form 05
Infection	☐ Yes	☐ No	If yes, complete Form 06
Malignancy/LPD	☐ Yes	☐ No	If yes, complete Form 07
Coronary revascularization	☐ Yes	☐ No	If yes, complete Form 09
Death	☐ Yes	☐ No	If yes, complete Form 10
Retransplantation	☐ Yes	☐ No	If yes, complete Forms 11, 1T, 02, and 03
Diabetes requiring insulin	☐ Yes	☐ No	

Other major events, specify: ____________
____

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