# Transplant Candidate Registration Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Submitting this paper form does not add your patient to the waiting list.



## Provider Information

Organ Registered: **Kidney**

Provider Number _____ UNOS Center Code _____ Center Name _____

Date placed on list: _____

## Candidate Information

Name: _____ (Last / First / MI) Previous Surname: _____

DOB: _____ SSN: _____ HIC: _____ Gender: ◯ Male ◯ Female

State of Permanent Residence: _____ Permanent Zip Code: _____ Waiting Zip Code: _____

**Ethnicity** ◯ Hispanic/Latino ◯ Non-Hispanic/Non-Latino

**Race**

- ◯ White
- ◯ Black or African American
- ◯ American Indian or Alaskan Native
- ◯ Asian
- ◯ Native Hawaiian or other Pacific Islander
- ◯ Mid-East or Arabian
- ◯ Indian Sub-Continent

**Citizenship** (Select one)

- ◯ U.S. Citizen
- ◯ Non-Resident Alien
  Home country: _____
- ◯ Resident Alien

**Highest Education Level** (Select one)

- ◯ None
- ◯ Grade School (0-8)
- ◯ High School (9-12)
- ◯ Attended College/Technical School
- ◯ Associate/Bachelor Degree
- ◯ Post-College Graduate Degree
- ◯ Unknown

**Medical Condition** (Select one)

- ◯ Patient in Intensive Care Unit
- ◯ Hospitalized, but not in Intensive Care Unit
- ◯ Not hospitalized

**Patient on Life Support**

(Please provide for all patients regardless of medical status)

◯ Yes ◯ No

(Check applicable)

- ☐ ECMO
- ☐ PGE
- ☐ Ventilator
- ☐ IABP
- ☐ IV Inotropes
- ☐ Other mechanism
  Specify: _____

VAD Brands

- ◯ Cardio West
- ◯ Abiomed
- ◯ Novacor
- ◯ Heartmate
- ◯ Thoratec
- ◯ Other VAD, specify: _____

**Functional Status** (Select one) (How does patient perform daily activities?)

- ◯ No activity limitations. (NYHA Class I or Class II)
- ◯ Performs activities of daily living with some assistance. (NYHA Class III)
- ◯ Performs activities of daily living with total assistance. (NYHA Class IV)
- ◯ N/A Patient hospitalized
- ◯ Unknown

**Employment Status** (Select one) (Working = Employed, Home, School)

- ◯ Working Full Time
- ◯ Working Part Time By Choice
- ◯ Working Part Time Due to Disease
- ◯ Working Part Time, Reason Unknown
- ◯ Not Working By Choice
- ◯ Not Working Due to Disease
- ◯ Not Working, Unable to Find Employment
- ◯ Not Working, Reason Unknown
- ◯ Retired
- ◯ Employment Status Unknown
- ◯ Patient Less Than Five Years Old

**Previous Transplants**

◯ Yes ◯ No

If Yes, give the number of previous transplants for each organ type and latest transplant date.

| | Number | Date |
|---|---|---|
| Kidney | | |
| Liver | | |
| Pancreas (whole) | | |
| Pancreas (islet cells) | | |
| Heart | | |
| Lung | | |
| Intestine | | |
| Bone Marrow | | |

**Source of Payment**

(Check Yes, No or Unknown for each secondary source of payment)

| Primary (Largest %, Select one) | Secondary | | |
|---|---|---|---|
| ◯ Medicare | ◯ Y | ◯ N | ◯ U |
| ◯ Medicaid | ◯ Y | ◯ N | ◯ U |
| ◯ US/State Government Agency | ◯ Y | ◯ N | ◯ U |
| ◯ Private Insurance | ◯ Y | ◯ N | ◯ U |
| ◯ HMO/PPO | ◯ Y | ◯ N | ◯ U |
| ◯ Self | ◯ Y | ◯ N | ◯ U |
| ◯ Donation | ◯ Y | ◯ N | ◯ U |
| ◯ Free Care | ◯ Y | ◯ N | ◯ U |
| ◯ Dept. of Veterans Affairs | | | |
| ◯ Pending | | | |
| ◯ Foreign Govt., Specify: _____ | | | |

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Name: _____



## Clinical Information

Height _____ **ft.** _____ **in.** **OR** _____ **cm**
Weight _____ **lbs.** **OR** _____ **kg**

**ABO Blood**

Group: _____
Rh: _____

**Primary Diagnosis**

(Use codes) _____
If other, specify: _____

**General Medical Factors**

**Diabetes**

- ○ No Diabetes
- ○ Insulin Dependent Diabetes
- ○ Non-Insulin Dependent Diabetes
- ○ Diabetes, Dependency Unknown
- ○ Unknown

**Dialysis**

- ○ No Dialysis
- ○ Hemodialysis
- ○ Peritoneal Dialysis

**Peptic Ulcer Disease**

- ○ No
- ○ Yes, Drug Treated
- ○ Yes, Not Drug Treated
- ○ Yes, Drug Treatment Unknown
- ○ Unknown

**Angina/Coronary Artery Disease**

- ○ No
- ○ Angina, Unstable
- ○ Angina, Stable
- ○ Angina, Stability Unknown
- ○ Unknown

| | | | |
|---|---|---|---|
| Drug Treated Systemic Hypertension | ○ Y | ○ N | ○ U |
| Symptomatic Cerebrovascular Disease | ○ Y | ○ N | ○ U |
| Symptomatic Peripheral Vascular Disease | ○ Y | ○ N | ○ U |
| Drug Treated COPD | ○ Y | ○ N | ○ U |
| Pulmonary Embolism (within last 6 months) | ○ Y | ○ N | ○ U |
| Any Previous Transfusions | ○ Y | ○ N | ○ U |
| Any Previous Malignancy (Exclude non-melanoma skin cancer) | ○ Y | ○ N | ○ U |
| PRA > 10% (with DTT or DTE testing) | ○ Y | ○ N | ○ U |

Most recent absolute Creatinine _____ mg/dl
Total Serum Albumin _____ g/dl

**Kidney Medical Factors**

| | | | |
|---|---|---|---|
| Exhausted vascular access | ○ Y | ○ N | ○ U |
| Exhausted peritoneal access | ○ Y | ○ N | ○ U |

Age of diabetes onset _____ yrs
Creatinine clearance _____ ml/min
Creatinine clearance method:
○ Isotope ○ Calculated ○ Measured Standard



Person completing form: _____ Date completed: _____

# Kidney Transplant Recipient Registration Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

Provider Number | Center Code | Transplant Center Name | Surgeon Name | UPIN Number

## Recipient Information

Name: Last First MI Transplant Date:

DOB: SSN: HIC: Gender: ◯ Male ◯ Female

## Patient Status

Primary Diagnosis (Use code) Specify:

**Patient Status**

Date: of Report or Death

◯ Living

◯ Dead Cause of Death: (Use code)

Specify:

◯ Retransplanted prior to hospital discharge

**Transplant Hospitalization**

Date of discharge from transplant center:

Date of admission to transplant center:

Was patient transferred from another hospital prior to transplant?

◯ Yes ◯ No

If Yes, date of admission to transferring hospital:

**Medical Condition at Time of Transplant** (Select one)

◯ Patient in Intensive Care Unit

◯ Hospitalized, but not in Intensive Care Unit

◯ Not hospitalized

**Patient on Life Support** ◯ Yes ◯ No

(Please provide for all patients regardless of medical status)

**Functional Status** (How does the patient perform activities of daily living? Select one)

◯ No activity limitations. (NYHA Class I or Class II)

◯ Performs activities of daily living with some assistance. (NYHA Class III)

◯ Performs activities of daily living with total assistance. (NYHA Class IV)

◯ N/A Patient hospitalized

◯ Unknown

**Employment Status** (Select one) (Working = Employed, Home, School)

◯ Working Full Time

◯ Working Part Time By Choice

◯ Working Part Time Due to Disease

◯ Working Part Time, Reason Unknown

◯ Not Working By Choice

◯ Not Working Due to Disease

◯ Not Working, Unable to Find Employment

◯ Not Working, Reason Unknown

◯ Retired

◯ Employment Status Unknown

◯ Patient Less Than Five Years Old

## Donor Information

Donor Type:

UNOS Donor ID | Donor Name: Last First

**Source of Payment** (Check Yes, No or Unk for each secondary source)

| Primary (Largest %, Select one) | Secondary | | |
|---|---|---|---|
| ◯ Medicare | ◯ Y | ◯ N | ◯ U |
| ◯ Medicaid | ◯ Y | ◯ N | ◯ U |
| ◯ US/State Government Agency | ◯ Y | ◯ N | ◯ U |
| ◯ Private Insurance | ◯ Y | ◯ N | ◯ U |
| ◯ HMO/PPO | ◯ Y | ◯ N | ◯ U |
| ◯ Self | ◯ Y | ◯ N | ◯ U |
| ◯ Donation | ◯ Y | ◯ N | ◯ U |
| ◯ Free Care | ◯ Y | ◯ N | ◯ U |
| ◯ Dept. of Veterans Affairs | | | |
| ◯ Foreign Gov't. Specify: | | | |

## Pretransplant Clinical Information

**Previous Kidney Transplants** ◯ Yes ◯ No

If Yes, number of previous kidney transplants:

| Previous Tx | Transplant Date | Graft Failure Date |
|---|---|---|
| Most recent | | |
| 2nd most recent | | |
| 3rd most recent | | |

**Pretransplant Dialysis**

◯ None ◯ Hemodialysis ◯ Peritoneal dialysis

If Yes, date first dialyzed:

Average daily insulin: units

Serum Creatinine at time of transplant: mg/dl

Creatinine clearance: ml/min

Creatinine clearance method:

◯ Isotope ◯ Calculated ◯ Measured standard

**Pretransplant Serology**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HIV | Screening | P | N | U | ND | I | C |
| | Confirmation | P | N | U | ND | I | C |
| CMV | IgG | P | N | U | ND | I | C |
| | IgM | P | N | U | ND | I | C |
| | DNA | P | N | U | ND | I | C |
| Hepatitis B | Core Antibody | P | N | U | ND | I | C |
| | Surface Antigen | P | N | U | ND | I | C |
| | HBV DNA | P | N | U | ND | I | C |
| Hepatitis C | Antibody Screen | P | N | U | ND | I | C |
| | RIBA Test | P | N | U | ND | I | C |
| | HCV RNA | P | N | U | ND | I | C |
| Epstein Barr Virus | IgG | P | N | U | ND | I | C |
| | IgM | P | N | U | ND | I | C |
| | DNA | P | N | U | ND | I | C |

# Kidney Transplant Recipient Registration Form

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Name: _____ 

**Biopsy of Donor Kidney at Transplant Center**

- ◯ No biopsy done
- ◯ Frozen Left Kidney
- ◯ Permanent Left Kidney
- ◯ Frozen Right Kidney
- ◯ Permanent Right Kidney
- ◯ Frozen En-bloc Kidney
- ◯ Permanent En-bloc Kidney

Kidney Results:

| Glomerulosclerosis % | Fibrosis | Arteriolosclerosis |
|---|---|---|
| ◯ 0-5 | ◯ None | ◯ None |
| ◯ 6-10 | ◯ Mild | ◯ Mild |
| ◯ 11-15 | ◯ Moderate | ◯ Moderate |
| ◯ 16-20 | ◯ Large | ◯ Large |
| ◯ > 20 | | |

Pretransplant Blood Transfusions:
◯ 0 ◯ 1-5 ◯ 6-10 ◯ >10 ◯ Unk

Date of last transfusion: _____

Donor specific transfusions? ◯ Yes ◯ No ◯ Unk

**Number of previous pregnancies:**
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ >5 ◯ Unk

**Any known malignancies since listing:** ◯ Yes ◯ No ◯ Unk

## Transplant Clinical Information

**Multiple Organ Recipient:** _____

**Procedure Type:** _____

**Preservation Information**

Total Cold Ischemic Time: _____ hrs
Anastomotic Time: _____ min
Warm Ischemic Time: _____ min
Total Pump Time: _____ hrs _____ min

**Number of blood transfusions at time of transplant:** _____

## Post Transplant Clinical Information

Graft Status: ◯ Functioning ◯ Failed

Resumed maintenance dialysis: ◯ Yes ◯ No

If Yes, date resumed: _____
Dialysis center provider #: _____
Dialysis center name: _____
If failed, date of graft failure: _____

Cause of graft failure (Check Yes, No or Unknown for each contributory cause of graft failure)

| Primary (Check one) | Contributory | | |
|---|---|---|---|
| ◯ Hyperacute rejection | | | |
| ◯ Acute rejection | ◯ Y | ◯ N | ◯ U |
| ◯ Primary failure | | | |
| ◯ Graft thrombosis | ◯ Y | ◯ N | ◯ U |
| ◯ Infection | ◯ Y | ◯ N | ◯ U |
| ◯ Surgical complications | ◯ Y | ◯ N | ◯ U |
| ◯ Urological complications | ◯ Y | ◯ N | ◯ U |
| ◯ Recurrent disease | ◯ Y | ◯ N | ◯ U |
| ◯ Other: _____ | Other: _____ | | |

Most recent Serum Creatinine prior to discharge: _____ mg/dl

| | | |
|---|---|---|
| Did kidney produce > 40 ml of urine in the first 24 hours? | ◯ Y | ◯ N |
| Did patient need dialysis within first week? | ◯ Y | ◯ N |
| Did Creatinine decline by 25% or more in first 24 hours on 2 separate serum samples taken within the first 24 hours? | ◯ Y | ◯ N |

**Rejection Information**

| | | |
|---|---|---|
| Patient treated for rejection? | ◯ Y | ◯ N |
| If Yes, biopsy done? | ◯ Y | ◯ N |
| If Yes, rejection confirmed? | ◯ Y | ◯ N |
| BANFF Level: | ◯ Y | ◯ N |

Stages: ◯ 1A ◯ 1B ◯ 2 ◯ 3

Height _____ **ft.** _____ **in.** **OR** _____ **cm**
Weight _____ **lbs.** **OR** _____ **kg**

## Treatment

**Immunosuppressive Information**

| | | |
|---|---|---|
| Are any medications given currently for maintenance or anti-rejection: | ◯ Y | ◯ N |
| Did the patient participate in any clinical research protocol for immunosuppressive medications: | ◯ Y | ◯ N |

If Yes, specify: _____

**Other Therapy**

| | | |
|---|---|---|
| Photopheresis | ◯ Y | ◯ N |
| Plasmapheresis | ◯ Y | ◯ N |
| Total Lymphoid Irradiation (TLI) | ◯ Y | ◯ N |

**Biologicals/Vaccines**

| | | |
|---|---|---|
| Cytogam (CMV) | ◯ Y | ◯ N |
| Gamimune N 10% | ◯ Y | ◯ N |
| Gammagard SD | ◯ Y | ◯ N |
| Acyclovir (Zovirax) | ◯ Y | ◯ N |
| Ganciclovir (Cytovene) | ◯ Y | ◯ N |
| HBIG (Hepatitis B Immume Globulin) | ◯ Y | ◯ N |
| Flu Vaccine (Influenza virus) | ◯ Y | ◯ N |

Other: _____
Other: _____



Person completing form: _____ Date completed: _____

# Immunosuppression Treatment

(Please print or type all information)

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Recipient Information

Name: _____
Last First MI

_____ _____ _____
Provider Number Center Code Tx Center Name

## Donor Information

_____ _____
UNOS Donor ID Donor Name: Last First

### Immunosuppression Therapy

| | Induct | Days | Maint | Anti-rej |
|---|---|---|---|---|
| **STEROIDS** | | | | |
| Prednisone (Deltasone, Orasone) | ☐ | _____ | ☐ | ☐ |
| Methylprednisolone (Solu-medrol, Medrol, A-Methapred) | ☐ | _____ | ☐ | ☐ |
| **T-CELL ACTIVATION INHIBITORS** | | | | |
| Cyclosporin A (CSA, Sandimmune, CyA, CyS) | ☐ | _____ | ☐ | ☐ |
| Neoral (CyA-NOF) | ☐ | _____ | ☐ | ☐ |
| FK506 (Prograf, Tacrolimus) | ☐ | _____ | ☐ | ☐ |
| Deoxyspergualin (DSG, 15-DSG, Gusperimus, Spanidin) | ☐ | _____ | ☐ | ☐ |
| Rapamycin (RAPA, Sirolimus, Rapamune) | ☐ | _____ | ☐ | ☐ |
| Gengraf (Abbot CyA) | ☐ | _____ | ☐ | ☐ |
| Certican (RAD, Enverolimus) | ☐ | _____ | ☐ | ☐ |
| **ANTIMETABOLITES** | | | | |
| Azathioprine (AZA, Imuran) | ☐ | _____ | ☐ | ☐ |
| Mycophenolate Mofetil (MMF, Cellcept, RS61443) | ☐ | _____ | ☐ | ☐ |
| Cytoxan (Cyclophosphamide) | ☐ | _____ | ☐ | ☐ |
| Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex) | ☐ | _____ | ☐ | ☐ |
| Brequinar Sodium (BRQ) | ☐ | _____ | ☐ | ☐ |
| Leflunomide (LFL) | ☐ | _____ | ☐ | ☐ |
| Mizoribine (Bredinin) | ☐ | _____ | ☐ | ☐ |
| **ANTI-LYMPHOCYTE RECEPTOR ANTIBODIES** | | | | |
| T10B9 (Medimmune) | ☐ | _____ | ☐ | ☐ |
| ATG (Atgam, Anti-thymocyte Globulin)/NRATG/NRATS | ☐ | _____ | ☐ | ☐ |
| OKT3 (Orthoclone, Muromonab) | ☐ | _____ | ☐ | ☐ |
| Thymoglobulin | ☐ | _____ | ☐ | ☐ |
| Zenapax | ☐ | _____ | ☐ | ☐ |
| Simulect | ☐ | _____ | ☐ | ☐ |
| DAB486 - IL - 2 | ☐ | _____ | ☐ | ☐ |
| Anti - ICAM - 1 | ☐ | _____ | ☐ | ☐ |
| **CYTOKINE INHIBITORS** | | | | |
| IL - 1 Receptor Antagonist | ☐ | _____ | ☐ | ☐ |
| Anti - IL - 6 | ☐ | _____ | ☐ | ☐ |
| **OTHER IMMUNOSUPPRESSIVE MEDICATION** | | | | |
| Other: _____ | ☐ | _____ | ☐ | ☐ |
| Other: _____ | ☐ | _____ | ☐ | ☐ |



Person completing form: _____ Date completed: _____

# Cadaver Donor Registration Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

OPO Provider Number _____ Center Code _____ OPO Center Name _____ Donor Hospital Provider Number _____ Donor Hospital Name _____

Date of Referral call: _____ **Recovered outside U.S:** ◯ Y ◯ N If Yes, country: _____

## Donor Information

UNOS Donor ID: _____

Name: _____ (Last) _____ (First) DOB: _____ If Unknown, give age: _____

Gender: ◯ Male ◯ Female Home City: _____ State: _____ Home Zip Code: _____

**Ethnicity** ◯ Hispanic/Latino ◯ Non-Hispanic/Non-Latino

**Race**

- ◯ White
- ◯ Black or African American
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Native Hawaiian or other Pacific Islander
- ◯ Mid-East or Arabian
- ◯ Indian Sub-Continent

**Citizenship** (Select one)

- ◯ U.S. Citizen
- ◯ Resident Alien
- ◯ Non-Resident Alien, specify country
  Home country: _____

**Cause of Death** (Select one)

- ◯ Anoxia/Cardiac Arrest
- ◯ Cerebrovascular/Stroke
- ◯ Head Trauma
- ◯ CNS Tumor
- ◯ Other, specify: _____

**Mechanism of Death** (Select one)

- ◯ Drowning
- ◯ Seizure
- ◯ Drug Intoxication
- ◯ Asphyxiation
- ◯ Cardiovascular
- ◯ Electrical
- ◯ Gunshot Wound
- ◯ None of the Above
- ◯ Stab
- ◯ Blunt Injury
- ◯ Sudden Infant Death
- ◯ Intracranial Hemorrhage /Stroke
- ◯ Death from Natural Causes

**Circumstances of Death** (Select one)

- ◯ Motor Vehicle Accident
- ◯ Alleged Suicide
- ◯ Alleged Homicide
- ◯ Alleged Child Abuse
- ◯ Non-Motor Vehicle Accident
- ◯ Death from Natural Causes
- ◯ None of the Above

## Procurement and Consent

**Was donor suitable for procurement of organs:** ◯ Y ◯ N

If No, select one primary reason:

- ◯ HIV +
- ◯ HCV +
- ◯ Hepatitis B +
- ◯ Tuberculosis
- ◯ Brain death criteria not met
- ◯ Medical History
- ◯ Social History
- ◯ Cancer
- ◯ Age
- ◯ Other, specify: _____

Was Death reported to Medical Examiner/Coroner:

- ◯ No
- ◯ Medical examiner consented
- ◯ Medical examiner refused consent
- ◯ Unknown

Was the donor's wish to donate organs known to the family prior to donation request: ◯ Y ◯ N ◯ U

Was a formal organ donation request made: (Select one)

- ◯ No
- ◯ Yes, family initiated
- ◯ Approached by physican
- ◯ Approached by nurse
- ◯ Approached by clergy
- ◯ Approached by OPO Coordinator
- ◯ Approached by Social Worker
- ◯ Other, Specify: _____

Written consent for organ donation obtained by: (Select one)

- ◯ No consent obtained
- ◯ OPO Coordinator
- ◯ Social Worker
- ◯ Other, specify: _____
- ◯ Physician
- ◯ Nurse
- ◯ Clergy

Was the consent based solely on written documentation of the patient? ◯ Y ◯ N

If Yes, indicate mechanisms:

- ☐ Driver's license
- ☐ Donor card
- ☐ Donor registry
- ☐ Living will
- ☐ Attorney in fact

Other, specify: _____

**Consent Information**

Tissue Requested ◯ Y ◯ N

If no, reason code: _____

Other, Specify: _____

Tissue Consented ◯ Y ◯ N

If no, reason code: _____

Other, Specify: _____

## Clinical Information

**ABO Blood**

Group: _____ Rh: _____

Height _____ **ft.** _____ **in.** **OR** _____ **cm**

Weight _____ **lbs.** **OR** _____ **kg**



Person completing form: _____ Date completed: _____

# Cadaver Donor Registration Form

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Name: _____ 

**Terminal Lab Data** (U=Unknown, ND=Not Done )

Serum Creatinine_____ mg/dl
BUN _____ mg/dl
Total Bilirubin _____ mg/dl
SGOT/AST _____ u/ml
SGPT/ALT _____ u/ml
Protein in urine ◯ Y ◯ N ◯ U
Last Serum sodium prior to procurement > 170 mEq/l: ◯ Y ◯ N ◯ U
Pancreas: (PA donors only)
Serum Lipase _____ u/L
Serum Amylase _____ u/L

**Medications given to donor** (24 hours prior to cross clamp)

| | | | |
|---|---|---|---|
| Anticonvulsants | ◯ Y | ◯ N | ◯ U |
| Antihypertensives | ◯ Y | ◯ N | ◯ U |
| Vasodilators | ◯ Y | ◯ N | ◯ U |
| Dopamine | ◯ Y | ◯ N | ◯ U |
| Dobutamine | ◯ Y | ◯ N | ◯ U |
| DDAVP | ◯ Y | ◯ N | ◯ U |

Other, specify: _____
Other, specify: _____
Other, specify: _____

**Serology**

| | | | | | | |
|---|---|---|---|---|---|---|
| Anti-HIV I | P | N | U | ND | I | C |
| Anti-HIV II | P | N | U | ND | I | C |
| Anti-HTVL I | P | N | U | ND | I | C |
| Anti-HTVL II | P | N | U | ND | I | C |
| RPR-VDRL | P | N | U | ND | I | C |
| Anti-CMV | P | N | U | ND | I | C |
| HBsAg | P | N | U | ND | I | C |
| Anti-HBC | P | N | U | ND | I | C |
| Anti-HCV | P | N | U | ND | I | C |

**Donor Management** (Pretreatment medications given after brain death declared and 24 hours prior to procurement)

Did donor receive prerecovery medication: ◯ Y ◯ N ◯ U
If Yes, check Yes, No or Unknown for each of the following:

| | | | |
|---|---|---|---|
| Steriods | ◯ Y | ◯ N | ◯ U |
| Diuretics | ◯ Y | ◯ N | ◯ U |
| T3 | ◯ Y | ◯ N | ◯ U |
| T4 | ◯ Y | ◯ N | ◯ U |

Other, specify: _____
Other, specify: _____
Other, specify: _____
Other, specify: _____

Transfusion units prior to surgery: (This hospitalization)
◯ 0 ◯ 1-5 ◯ 6-10 ◯ >10 ◯ Unk
Transfusion units intraoperatively:
◯ 0 ◯ 1-5 ◯ 6-10 ◯ >10 ◯ Unk
Three or more inotropic agents at time of incision: ◯ Y ◯ N
Cardiac arrest since neurological event that lead to declaration of brain death: ◯ Y ◯ N
If Yes, duration of resuscitation: _____ min

**Clinical Infection:** ◯ Y ◯ N ◯ U

| Source | Confirmed by Culture |
|---|---|
| ☐ Blood | ◯ Y ◯ N |
| ☐ Lung | ◯ Y ◯ N |
| ☐ Urine | ◯ Y ◯ N |
| ☐ Other, specify: _____ | ◯ Y ◯ N |

## Heart Donor's Cardiac Function

**History of previous MI:** ◯ Y ◯ N
LV ejection fraction: _____ %
Method:
◯ Echo
◯ MUGA
◯ Angiogram
If LV ejection fraction < 50%:
Segmental abnormalities ◯ Y ◯ N
Global abnormalities ◯ Y ◯ N
Coronary angiogram: ◯ Y ◯ N
If Yes, normal: ◯ Y ◯ N
If abnormal, number of vessels with > 50% stenosis: ◯ 1 ◯ 2 ◯ 3
**Inotropic support:** ◯ Y ◯ N
If Yes, list the agents used at acceptance and at time of procurement:

**At Acceptance:**

| Agent | Dosage (mg/kg/min) | Time Started (military time) |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

**At Time of Procurement:**

| Agent | Dosage (mg/kg/min) | Time Started (military time) |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

**Right heart catheterization:** ◯ Y ◯ N
If Yes:
CVP _____ PCW Pressure _____
PA Systolic _____ CO _____
PA Diastolic _____
Biopsy Performed:
◯ No Biopsy
◯ Yes, Myocarditis
◯ Yes, Negative Biopsy Result
◯ Yes, Other Diagnosis, Specify
Specify: _____



Person completing form: _____ Date completed: _____

# Cadaver Donor Registration Form

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Name: _____



## Donor History

**Chemical Use:**

| | | | |
|---|---|---|---|
| Cigarette Use (> 20 pack years) -Ever | ◯ Y | ◯ N | ◯ U |
| AND continued in last six months | ◯ Y | ◯ N | ◯ U |
| Alcohol Dependency -Ever | ◯ Y | ◯ N | ◯ U |
| AND continued in last six months | ◯ Y | ◯ N | ◯ U |
| IV Drug Use -Ever | ◯ Y | ◯ N | ◯ U |
| AND continued in last six months | ◯ Y | ◯ N | ◯ U |
| Cocaine Use -Ever | ◯ Y | ◯ N | ◯ U |
| AND continued in last six months | ◯ Y | ◯ N | ◯ U |
| Other Drug Use -Ever | ◯ Y | ◯ N | ◯ U |
| AND continued in last six months | ◯ Y | ◯ N | ◯ U |

**History of Diabetes:** ◯ Y ◯ N ◯ U

If Yes, duration:
◯ 0-5 Years ◯ 6-10 Years ◯ >10 Years ◯ Unk

Insulin Dependent: ◯ Y ◯ N

If Yes, how long:
◯ 0-5 Years ◯ 6-10 Years ◯ >10 Years ◯ Unk

**History of Hypertension:** ◯ Y ◯ N ◯ U

If Yes, duration:
◯ 0-5 Years ◯ 6-10 Years ◯ >10 Years ◯ Unk

If Yes, method of control:

| | | | |
|---|---|---|---|
| Diet | ◯ Y | ◯ N | ◯ U |
| Diuretics | ◯ Y | ◯ N | ◯ U |
| Other Hypertensive Medication | ◯ Y | ◯ N | ◯ U |

**History of Cancer:** ◯ Y ◯ N ◯ U

If Yes, cancer free interval _____ years.

If Yes, Primary site: (Select one)

**Skin**
- ◯ Squamous, basal cell
- ◯ Melanoma

**CNS Tumor**
- ◯ Astrocytoma
- ◯ Glioblastoma multiforme
- ◯ Medulloblastoma
- ◯ Neuroblastoma
- ◯ Angioblastoma
- ◯ Meningioma
- ◯ Intracranial surgery
- ◯ Intracranial no surgery
- ◯ CNS Other

**Genitourinary**
- ◯ Bladder
- ◯ Uterine Cervix
- ◯ Uterine body Endometrial
- ◯ Uterine body
- Choriocarcinoma
- ◯ Vulva
- ◯ Ovarian
- ◯ Penis, Testicular
- ◯ Prostate
- ◯ Kidney
- ◯ Unknown genitourinary

**Gastrointestinal**
- ◯ Esophageal
- ◯ Stomach
- ◯ Small Intestine
- ◯ Colo-rectal
- ◯ Liver & biliary tract
- ◯ Pancreas

- ◯ Breast
- ◯ Thyroid
- ◯ Tongue/Throat
- ◯ Larynx
- ◯ Lung (include bronchial)
- ◯ Leukemia/Lymphoma
- ◯ Other, specify: _____

**Cancer at procurement**

| | | | |
|---|---|---|---|
| Intracranial | ◯ Y | ◯ N | ◯ U |
| Extracranial | ◯ Y | ◯ N | ◯ U |
| Skin | ◯ Y | ◯ N | ◯ U |

**Lifestyle Factors:**

| | | | |
|---|---|---|---|
| History of prison | ◯ Y | ◯ N | ◯ U |
| Tattoos | ◯ Y | ◯ N | ◯ U |
| Sexual promiscuity | ◯ Y | ◯ N | ◯ U |

Other: _____
Other: _____
Other: _____

## Organ Recovery

**Recovery Date** (donor to OR): _____

**Non-Heart beating donor:** ◯ Y ◯ N

If Yes, controlled: ◯ Y ◯ N ◯ U

If Yes, core cooling used: ◯ Y ◯ N ◯ U

If Yes, estimated warm ischemic time: _____ min

**Clamp date:** _____

**Clamp time** (Military time): _____ Time zone: _____

| **Left Kidney Biopsy:** ◯ Y ◯ N | **Right Kidney Biopsy:** ◯ Y ◯ N |
|---|---|
| Glomerulosclerosis % | Glomerulosclerosis % |
| ◯ 0-5 | ◯ 0-5 |
| ◯ 6-10 | ◯ 6-10 |
| ◯ 11-15 | ◯ 11-15 |
| ◯ 16-20 | ◯ 16-20 |
| ◯ > 20 | ◯ > 20 |
| **Pump:** ◯ Y ◯ N | **Pump:** ◯ Y ◯ N |
| Flow rate: _____ cc's/min | Flow rate: _____ cc's/min |
| Perfusion pressure Systolic: _____ mm/Hg | Perfusion pressure Systolic: _____ mm/Hg |
| Perfusion pressure Diastolic: _____ mm/Hg | Perfusion pressure Diastolic: _____ mm/Hg |

**Liver biopsy:** ◯ Y ◯ N

% Fatty:
◯ 0-19 ◯ 20-35 ◯ > 35

Portal infiltrates: ◯ Y ◯ N

Fibrosis: ◯ Y ◯ N

**Pump** ◯ Y ◯ N

Flow rate: _____ cc's/min
Perfusion pressure Systolic: _____ mm/Hg
Perfusion pressure Diastolic: _____ mm/Hg

**Lung:**

$pO_2$ on 100%: _____

**Left Lung:**

| | | | |
|---|---|---|---|
| Bronchoscopic abnormalities: | ◯ Y | ◯ N | |
| If Yes, purulent drainage: | ◯ Y | ◯ N | |
| Chest X-ray abnormalities: | ◯ Y | ◯ N | |
| If Yes, Infiltrate: | ◯ Y | ◯ N | |

If Yes: ☐ Upper ☐ Mid ☐ Lower

**Right Lung:**

| | | | |
|---|---|---|---|
| Bronchoscopic abnormalities: | ◯ Y | ◯ N | |
| If Yes, purulent drainage: | ◯ Y | ◯ N | |
| Chest X-ray abnormalities: | ◯ Y | ◯ N | |
| If Yes, Infiltrate: | ◯ Y | ◯ N | |

If Yes: ☐ Upper ☐ Mid ☐ Lower



Person completing form: _____ Date completed: _____

# Cadaver Donor Registration Form

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Name: _____



**Kidney Right** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Liver Segment 2** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Kidney Left** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Intestine** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Kidney Double/Enbloc** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Intestine Segment 1**-
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Pancreas** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Intestine Segment 2** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Pancreas Segment 1** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Heart** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Pancreas Segment 2** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Lung Right** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Liver** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Lung Left** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Liver Segment 1** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name

**Lung Double/En-bloc** -
Reason Code: _____ Other Specify: _____
Discard Code: _____ Other Specify: _____
Recov. Team # _____ Placed by: _____ Type Share: _____
Flush Solution: _____ Other Specify: _____
Storage Solution: _____ Other Specify: _____
Recipient Name SSN Provider # - Center Code - Tx Center Name



Person completing form: _____ Date completed: _____

# Cadaver Donor Referral Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

Date of Referral call: _____

OPO Provider Number _____ Center Code _____ OPO Center Name _____ Donor Hospital Provider Number _____ Donor Hospital Name _____

## Donor Information

UNOS Donor ID: _____

Name: _____ (Last) _____ (First) DOB: _____ If Unknown, give age: _____

Gender: ○ Male ○ Female Home City: _____ State: _____ Home Zip Code: _____

**Ethnicity** ○ Hispanic/Latino ○ Non-Hispanic/Non-Latino

**Race**

- ○ White
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ Mid-East or Arabian
- ○ Indian Sub-Continent
- ○ Unknown

**Citizenship** (Select one)

- ○ U.S. Citizen
- ○ Resident Alien
- ○ Non-Resident Alien, specify country
  Home country: _____
- ○ Unknown

**Cause of Death** (Select one)

- ○ Anoxia/Cardiac Arrest
- ○ Cerebrovascular/Stroke
- ○ Head Trauma
- ○ CNS Tumor

Other, specify: _____

**Mechanism of Death** (Select one)

- ○ Drowning
- ○ Seizure
- ○ Drug Intoxication
- ○ Asphyxiation
- ○ Cardiovascular
- ○ Electrical
- ○ Gunshot Wound
- ○ None of the Above
- ○ Stab
- ○ Blunt Injury
- ○ Sudden Infant Death
- ○ Intracranial Hemorrhage /Stroke
- ○ Death from Natural Causes

**Circumstances of Death** (Select one)

- ○ Motor Vehicle Accident
- ○ Alleged Suicide
- ○ Alleged Homicide
- ○ Alleged Child Abuse
- ○ Non-Motor Vehicle Accident
- ○ Death from Natural Causes
- ○ None of the Above

Was Death reported to Medical Examiner/Coroner:

- ○ No
- ○ Medical examiner consented
- ○ Medical examiner refused consent
- ○ Unknown

Was the donor's wish to donate organs known to the family prior to donation request: ○ Y ○ N ○ U

Was a formal organ donation request made: (Select one)

- ○ No
- ○ Yes, family initiated
- ○ Approached by physican
- ○ Approached by nurse
- ○ Approached by clergy
- ○ Approached by OPO Coordinator
- ○ Approached by Social Worker
- ○ Other, Specify: _____

Written consent for organ donation obtained by: (Select one)

- ○ No consent obtained
- ○ OPO Coordinator
- ○ Social Worker
- ○ Physician
- ○ Nurse
- ○ Clergy
- ○ Other, specify: _____

Was the consent based solely on written documentation of the patient? ○ Y ○ N

If Yes, indicate mechanisms:

- ☐ Driver's license
- ☐ Donor card
- ☐ Donor registry
- ☐ Living will
- ☐ Attorney in fact

Other, specify: _____

## Procurement and Consent

**Was donor suitable for procurement of organs:** ○ Y ○ N

If No, select one primary reason:

- ○ HIV +
- ○ HCV +
- ○ Hepatitis B +
- ○ Tuberculosis
- ○ Brain death criteria not met
- ○ Medical History
- ○ Social History
- ○ Cancer
- ○ Age

○ Other, specify: _____



Person completing form: _____ Date completed: _____

# Living Donor Registration

(Please print or type all information)

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

Provider Number _____ Center Code _____ Recipient Transplant Center Name _____

## Donor Information

Donor ID: _____

Name: _____ (Last) _____ (First) Transplant Date: _____

DOB: _____ SSN: _____ Gender: ◯ Male ◯ Female Blood Type: _____ Rh: _____

Home City: _____ Home State: _____ Home Zip Code: _____

**Living Donor Type:** (Indicate the relationship of the donor to the recipient by checking one.)

Living, Biologically Related
- ◯ Parent
- ◯ Child
- ◯ Identical Twin
- ◯ Full Sibling (Not Identical Twin)
- ◯ Half Sibling
- ◯ Other Relative, specify: _____

Living, Biologically Unrelated
- ◯ Spouse
- ◯ Other, specify: _____

**Ethnicity** ◯ Hispanic/Latino ◯ Non-Hispanic/Non-Latino

**Race**
- ◯ White
- ◯ Black or African American
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Native Hawaiian or other Pacific Islander
- ◯ Mid-East or Arabian
- ◯ Indian Sub-Continent

**Citizenship** (Select one)
- ◯ U.S. Citizen
- ◯ Resident Alien
- ◯ Non-Resident Alien, specify country
  Home country: _____

**Highest Education Level** (Select one)
- ◯ None
- ◯ Grade School (0-8)
- ◯ High School (9-12)
- ◯ Attended College/Technical School
- ◯ Associate/Bachelor Degree
- ◯ Post-College Graduate Degree
- ◯ Unknown

**Source of Payment**

(Check Yes, No or Unknown for each secondary source of payment)

| Primary (Largest %, Select one) | Secondary | | |
|---|---|---|---|
| ◯ Medicare | ◯ Y | ◯ N | ◯ U |
| ◯ Medicaid | ◯ Y | ◯ N | ◯ U |
| ◯ US/State Government Agency | ◯ Y | ◯ N | ◯ U |
| ◯ Private Insurance | ◯ Y | ◯ N | ◯ U |
| ◯ HMO/PPO | ◯ Y | ◯ N | ◯ U |
| ◯ Self | ◯ Y | ◯ N | ◯ U |
| ◯ Donation | ◯ Y | ◯ N | ◯ U |
| ◯ Free Care | ◯ Y | ◯ N | ◯ U |
| ◯ Dept. of Veterans Affairs | | | |
| ◯ Pending | | | |
| ◯ Foreign Govt. Specify: _____ | | | |

## Clinical Information

Height _____ **ft.** _____ **in.** **OR** _____ **cm**

Weight _____ **lbs.** **OR** _____ **kg**

**Serology**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HIV | Screening | P | N | U | ND | I | C |
| | Confirmation | P | N | U | ND | I | C |
| CMV | IgG | P | N | U | ND | I | C |
| | IgM | P | N | U | ND | I | C |
| | DNA | P | N | U | ND | I | C |
| Hepatitis B | Core Antibody | P | N | U | ND | I | C |
| | Surface Antigen | P | N | U | ND | I | C |
| | HBV DNA | P | N | U | ND | I | C |
| Hepatitis C | Antibody Screen | P | N | U | ND | I | C |
| | RIBA Test | P | N | U | ND | I | C |
| | HCV RNA | P | N | U | ND | I | C |
| Epstein Barr Virus | IgG | P | N | U | ND | I | C |
| | IgM | P | N | U | ND | I | C |
| | DNA | P | N | U | ND | I | C |

**Creatinine:** (Kidney donors)

Preoperative: _____ mg/dl

At Discharge: _____ mg/dl

**Kidney Procedure Type:**
- ◯ Transabdominal
- ◯ Laparoscopic
- ◯ Flank

**Blood Pressure (mmHg)**

Systolic Preoperative: _____ Systolic at Discharge: _____

Diastolic Preoperative: _____ Diastolic at Discharge: _____

**Length of hospital stay:** _____ days

**Bleeding requiring transfusion:**

◯ 0 ◯ 1-5 ◯ 6-10 ◯ >10 ◯ Unk

**Infections during hospitalization:** ◯ Y ◯ N

**Pulmonary Embolism during hospitalization:** ◯ Y ◯ N

**Return to OR after recovery of donor organ:** ◯ Y ◯ N

**Date of Death:** _____

Cause of Death: ◯ Donation Related ◯ Other Cause

## Organ Recovery

Organ Recovery Date: _____

Recovered outside the U.S: ◯ Y ◯ N

Specify Country: _____

Donor Recovery Facility _____

Donor Workup Facility _____

Organ(s) Recovered _____ Recipient Name: Last _____ First _____

Recipient SSN _____

UNOS/PHS/HCFA 3/22/01

Person completing form: _____ Date completed: _____

# Living Donor Follow-Up

(Please print or type all information)

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

Tx Provider Number _____ Center Code _____ Tx Center Name _____

Follow-up Number _____ Center Code _____ Follow-up Center Name _____

## Donor Information

Name: _____ (Last) _____ (First) Donor ID: _____

Recovery Date: _____ DOB: _____ SSN: _____ Gender: ○ Male ○ Female

## Patient Status

Date: _____ of Report, Last Seen or Death

- ○ Living
- ○ Dead
- ○ Lost to Follow-Up

Cause of Death: ○ Donation Related ○ Other Cause

## Clincial Information

Height _____ **ft.** _____ **in.** **OR** _____ **cm**

Weight _____ **lbs.** **OR** _____ **kg**

**Blood Pressure at Follow-Up:**

Diastolic: _____ mmHg Systolic: _____ mmHg

**Treatment of Kidney Donor Related Complications**

Serum Creatinine: _____ mg/dl

**Complications:**

- ☐ Antihypertensive Drugs (specify)

  _____

  _____

  _____
- ☐ Any Non-maintenance Dialysis
- ☐ Maintenance Dialysis
- ☐ Added to UNOS kidney transplant candidate waiting list

**Liver Donor**

Bilirubin: _____ mg/dl

AST: _____ U/ml

Alkaline Phosphate: _____ units/L

**Complications:**

- ☐ Bile Leak
- ☐ Hepatic Resection
- ☐ Abscess
- ☐ Liver Failure
- ☐ Added to UNOS liver transplant candidate waiting list

**Number of hospitalizations during follow-up period:** _____

Most recent diagnosis: _____

Second most recent diagnosis: _____

Third most recent diagnosis: _____



Person completing form: _____ Date completed: _____

# Donor Histocompatibility Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

OPO Provider Number _____ Center Code _____ OPO Center Name _____

Lab Provider Number _____ Center Code _____ Lab Name _____

## Donor Information

UNOS Donor ID _____ Donor Name: Last _____ First _____ Donor Type: _____

## Donor Center Histocompatibility Typing

Was HLA typing performed on this donor?

○ Y ○ N ○ U

**Date Typed:** _____

If donor HLA typed, complete the remainder of this section.

If donor was not HLA typed or typing status is Unknown, sign and return the form.

Target Source: (Select one)

- ○ Peripheral Blood Lymphocytes
- ○ Lymph Nodes
- ○ Spleen
- ○ Solid Matrix
- ○ Multiple
- ○ Thymocytes
- ○ Cell lines/Clonal Cells

**Typing Method Class I:**

○ Serology ○ Other, specify: _____

○ DNA

| | |
|---|---|
| A: | Bw4: |
| A: | Bw6: |
| B: | Cw: |
| B: | Cw: |

**Typing Method Class II:**

○ Serology ○ Other, specify: _____

○ DNA

| | |
|---|---|
| DR: | DQ: |
| DR: | DQ: |
| DR51: | DPw: |
| DR52: | DPw: |
| DR53: | |

## Recipient of a Living Donor Information

Living Recipient Name: Last _____ First _____ SSN: _____ Organ: _____

Tx Provider Number: _____ Center Code: _____ Tx Center Name: _____

**Haplotype Match Information:** (Select one)

○ 0 ○ 0.5 ○ 1 ○ 1.5 ○ 2 ○ Unk ○ N/A Donor Not Typed



Person completing form: _____ Date completed: _____

# Recipient Histocompatibility Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

Lab Provider Number _____ Center Code _____ Lab Center Name _____ Tx Provider Number _____ Center Code _____ Tx Center Name _____

## Recipient Information

Name: _____ (Last) _____ (First) _____ (MI) Organ(s): _____ Transplant Date: _____

DOB: _____ SSN: _____ HIC: _____ Gender: ○ Male ○ Female

## Donor Information

Donor Type: _____

UNOS Donor ID _____ Donor Name: Last _____ First _____

## Test Information

| | | |
|---|---|---|
| HLA typing done: If Yes, complete Section I. | ○ Y | ○ N |
| PRA testing done: If Yes, complete Section II. | ○ Y | ○ N |
| Crossmatch done: If Yes, complete Section III. | ○ Y | ○ N |
| Donor retyped at your center: If Yes, complete Section IV. | ○ Y | ○ N |

## Section I - Recipient HLA Typing

**Date Typed:** _____

Cell Source: _____ (Use code)

**Typing Method Class I:**

○ Serology ○ Other, specify: _____

○ DNA

| | |
|---|---|
| A: | Bw4: |
| A: | Bw6: |
| B: | Cw: |
| B: | Cw: |

**Typing Method Class II:**

○ Serology ○ Other, specify: _____

○ DNA

| | |
|---|---|
| DR: | DQ: |
| DR: | DQ: |
| DR51: | DPw: |
| DR52: | DPw: |
| DR53: | |

## Section II - Panel Reactive Antibody (%PRA)

Most Recent Serum Date: _____

| Cell Type: | Cell Source: | Technique: | PRA%: |
|---|---|---|---|
| | | | |

Peak Serum Date: _____

| Cell Type: | Cell Source: | Technique: | PRA%: |
|---|---|---|---|
| | | | |

## Section III - Crossmatch

**A. Most Recent**

| Serum Date: | Cell Type: | Target Source: | Technique: | Result: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Auto Crossmatch positive: ○ Y ○ N ○ Not done ○ U

**B. Positive Crossmatch with any other sera by any other method:** ○ Y ○ N

If Yes, give most recent positive Serum Date(s):

| Serum Date: | Cell Type: | Target Source: | Technique: | Result: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Auto Crossmatch positive: ○ Y ○ N ○ Not done ○ U

## Section IV - Donor Retyping

**Date Typed:** _____

Cell Source: _____ (Use code)

**Typing Method Class I:**

○ Serology ○ Other, specify: _____

○ DNA

| | |
|---|---|
| A: | Bw4: |
| A: | Bw6: |
| B: | Cw: |
| B: | Cw: |

**Typing Method Class II:**

○ Serology ○ Other, specify: _____

○ DNA

| | |
|---|---|
| DR: | DQ: |
| DR: | DQ: |
| DR51: | DPw: |
| DR52: | DPw: |
| DR53: | |



Person completing form: _____ Date completed: _____

# Kidney Transplant Recipient Follow-Up Form

(Please print or type all information)

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Provider Information

Provider Number | Center Code | Transplant Center Name

Follow-Up Provider Number | Center Code | Follow-Up Center Name

Physician Name | Physician UPIN

Follow-Up care provided by:
- ◯ Transplant Center
- ◯ Non-Transplant Center Specialty Physician
- ◯ Primary Care Physician (HMO/PPO)
- ◯ Other, specify: _____

City | State | Zip

## Recipient Information

Transplant Date: _____

Name: _____ (Last First MI) Discharge Date: _____

DOB: _____ SSN: _____ HIC: _____ Gender: ◯ Male ◯ Female

## Donor Information

Donor Type: _____

UNOS Donor ID | Donor Name: Last First

## Patient Status at Time of Follow-Up (Select one)

Date: _____ Patient Report, Death or Retransplant

- ◯ Living
- ◯ Dead Cause of Death: _____ (Use code)
  Specify: _____
- ◯ Lost to Follow-Up
- ◯ Retransplanted since last Follow-Up

**Patient transferred to new provider:** ◯ Y ◯ N

If Yes, transferred to UNOS member ◯ Y ◯ N

Transfer Date: _____

New Provider Number | New Provider Name

**Hospitalizations during follow-up period:** ◯ Y ◯ N ◯ U

Number of transplant related hospitalizations: _____

Was patient in ICU: ◯ Y ◯ N ◯ U

**Noncompliance**

Patient noncompliant during follow-up period: ◯ Y ◯ N ◯ U

If Yes, indicate areas of noncompliance
- ☐ Immunosuppression medication
- ☐ Patient unable to afford immunosuppression medications
- ☐ Other medication
  Other medication, specify: _____
- ☐ Other therapeutic regimen
  Other therapeutic regimen, specify: _____

**Functional Status at Follow-Up** (Select one) (How does the patient perform activities of daily living?)
- ◯ No activity limitations. (NYHA Class I or Class II)
- ◯ Performs activities of daily living with some assistance. (NYHA Class III)
- ◯ Performs activities of daily living with total assistance. (NYHA Class IV)
- ◯ N/A Patient hospitalized
- ◯ Unknown

**Employment Status** (Select one) (Working = Employed, Home, School)
- ◯ Working Full Time
- ◯ Working Part Time By Choice
- ◯ Working Part Time Due to Disease
- ◯ Working Part Time, Reason Unknown
- ◯ Not Working By Choice
- ◯ Not Working Due to Disease
- ◯ Not Working, Unable to Find Employment
- ◯ Not Working, Reason Unknown
- ◯ Retired
- ◯ Employment Status Unknown
- ◯ Patient Less Than Five Years Old

## Clinical Information

Height _____ **ft.** _____ **in.** **OR** _____ **cm**

Weight _____ **lbs.** **OR** _____ **kg**

**Graft Status** ◯ Functioning ◯ Failed

Dialysis since last follow-up: ◯ Y ◯ N ◯ U

Resumed maintenance dialysis ◯ Y ◯ N ◯ U

If Yes, date resumed: _____

Dialysis center provider #: _____

Dialysis center name: _____

If functioning, most recent Serum Creatinine: _____ mg/dl

If failed, failure date: _____

Cause of graft failure (Check Yes, No or Unknown for each contributory cause of graft failure)

| Primary (Check one) | Contributory |
|---|---|
| ◯ Acute rejection | ◯ Y ◯ N ◯ U |
| ◯ Chronic rejection | ◯ Y ◯ N ◯ U |
| ◯ Primary failure | |
| ◯ Graft thrombosis | ◯ Y ◯ N ◯ U |
| ◯ Infection | ◯ Y ◯ N ◯ U |
| ◯ Urological complications | ◯ Y ◯ N ◯ U |
| ◯ Recurrent disease | ◯ Y ◯ N ◯ U |
| ◯ Other: _____ | Other: _____ |

# Kidney Transplant Recipient Follow-Up Form

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Name: _____



**Patient treated for rejection:** ◯ Y ◯ N ◯ U

Number of rejection events: _____

**Serology**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HIV | Screening | P | N | U | ND | I | C |
| | Confirmation | P | N | U | ND | I | C |
| CMV | IgG | P | N | U | ND | I | C |
| | IgM | P | N | U | ND | I | C |
| | DNA | P | N | U | ND | I | C |
| Hepatitis B | Core Antibody | P | N | U | ND | I | C |
| | Surface Antigen | P | N | U | ND | I | C |
| | HBV DNA | P | N | U | ND | I | C |
| Hepatitis C | Antibody Screen | P | N | U | ND | I | C |
| | RIBA Test | P | N | U | ND | I | C |
| | HCV RNA | P | N | U | ND | I | C |
| Epstein Barr Virus | IgG | P | N | U | ND | I | C |
| | IgM | P | N | U | ND | I | C |
| | DNA | P | N | U | ND | I | C |

**Post transplant malignancies*** ◯ Y ◯ N ◯ U

Please report each type of Malignancy only once in the follow-up process.

Donor related ◯ Y ◯ N ◯ U

Recurrence of pre-transplant tumor ◯ Y ◯ N ◯ U

Post Tx De Novo solid tumor ◯ Y ◯ N ◯ U

Post Tx Lymphoproliferative Disease and Lymphoma ◯ Y ◯ N ◯ U

* **If Yes, complete Post Transplant Malignancy form.**

## Treatment

**Immunosuppressive Information**

Were any medications given during the follow-up period for maintenance or anti-rejection: ◯ Y ◯ N

If no maintenance medications are currently given, did the physician discontinue all immunosuppressive medications: ◯ Y ◯ N

Did the patient participate in any clinical research protocol for immunosuppressive medications: ◯ Y ◯ N

If Yes, specify: _____

**Other Therapy**

Photopheresis ◯ Y ◯ N

Plasmapheresis ◯ Y ◯ N

Total Lymphoid Irradiation (TLI) ◯ Y ◯ N

**Biologicals/Vaccines**

Cytogam (CMV) ◯ Y ◯ N

Gamimune N 10% ◯ Y ◯ N

Gammagard SD ◯ Y ◯ N

Acyclovir (Zovirax) ◯ Y ◯ N

Ganciclovir (Cytovene) ◯ Y ◯ N

HBIG (Hepatitis B Immume Globulin) ◯ Y ◯ N

Flu Vaccine (Influenza virus) ◯ Y ◯ N

Other: _____

Other: _____



Person completing form: _____ Date completed: _____

# Immunosuppression Treatment Follow-Up

(Please print or type all information)

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002



## Recipient Information

Name: _____
Last First MI

_____ _____ _____
Provider Number Center Code Tx Center Name

## Donor Information

_____ _____ Donor Type: _____
UNOS Donor ID Donor Name: Last First

| Immunosuppression Therapy | All Maint since last report | Maint at time of report | Anti-rej |
|---|---|---|---|
| **STEROIDS** | | | |
| Prednisone (Deltasone, Orasone) | ☐ | ☐ | ☐ |
| Methylprednisolone (Solu-medrol, Medrol, A-Methapred) | ☐ | ☐ | ☐ |
| **T-CELL ACTIVATION INHIBITORS** | | | |
| Cyclosporin A (CSA, Sandimmune, CyA, CyS) | ☐ | ☐ | ☐ |
| Neoral (CyA-NOF) | ☐ | ☐ | ☐ |
| FK506 (Prograf, Tacrolimus) | ☐ | ☐ | ☐ |
| Deoxyspergualin (DSG, 15-DSG, Gusperimus, Spanidin) | ☐ | ☐ | ☐ |
| Rapamycin (RAPA, Sirolimus, Rapamune) | ☐ | ☐ | ☐ |
| Gengraf (Abbot CyA) | ☐ | ☐ | ☐ |
| Certican (RAD, Enverolimus) | ☐ | ☐ | ☐ |
| **ANTIMETABOLITES** | | | |
| Azathioprine (AZA, Imuran) | ☐ | ☐ | ☐ |
| Mycophenolate Mofetil (MMF, Cellcept, RS61443) | ☐ | ☐ | ☐ |
| Cytoxan (Cyclophosphamide) | ☐ | ☐ | ☐ |
| Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex) | ☐ | ☐ | ☐ |
| Brequinar Sodium (BRQ) | ☐ | ☐ | ☐ |
| Leflunomide (LFL) | ☐ | ☐ | ☐ |
| Mizoribine (Bredinin) | ☐ | ☐ | ☐ |
| **ANTI-LYMPHOCYTE RECEPTOR ANTIBODIES** | | | |
| T10B9 (Medimmune) | ☐ | ☐ | ☐ |
| ATG (Atgam, Anti-thymocyte Globulin)/NRATG/NRATS | ☐ | ☐ | ☐ |
| OKT3 (Orthoclone, Muromonab) | ☐ | ☐ | ☐ |
| Thymoglobulin | ☐ | ☐ | ☐ |
| Zenapax | ☐ | ☐ | ☐ |
| Simulect | ☐ | ☐ | ☐ |
| DAB486 - IL - 2 | ☐ | ☐ | ☐ |
| Anti - ICAM - 1 | ☐ | ☐ | ☐ |
| **CYTOKINE INHIBITORS** | | | |
| IL - 1 Receptor Antagonist | ☐ | ☐ | ☐ |
| Anti - IL - 6 | ☐ | ☐ | ☐ |
| **OTHER IMMUNOSUPPRESSIVE MEDICATION** | | | |
| Other: _____ | ☐ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ | ☐ |



Person completing form: _____ Date completed: _____