

PEDIATRIC HEART TRANSPLANT STUDY

FORM 01: 2010: Initial Patient Entry at Listing (PG 1 of 2)

To be filled out at time of listing

ID#	P								
p	Institutional Code	Sequential Patient Number	Patient Initials	Tran #					

1. Institution Code: _____	2. Patient Number: _____	3. Patient Initials: _____	4. Height: <input type="checkbox"/> in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lb <input type="checkbox"/> kg
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5. Date of Birth: (MO DAY YR) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	6. Date of Listing: (MO DAY YR) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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8a. Race: (See Manual, check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander <input type="checkbox"/> Mid-east/Arabian <input type="checkbox"/> Indian Subcontinent <input type="checkbox"/> Other, specify: _____	8b. Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No
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9. Etiology: (Choose only ONE primary etiology)

<input type="checkbox"/> Myocarditis	(Cardiomyopathy continued)	<input type="checkbox"/> Congenital Heart Disease (if checked, complete below): <input type="checkbox"/> Complete AV Septal Defect <input type="checkbox"/> Congenitally Corrected Transposition <input type="checkbox"/> Ebstein's Anomaly <input type="checkbox"/> Hypoplastic Left Heart <input type="checkbox"/> Left Heart Valvar/Structural Hypoplasia <input type="checkbox"/> Pulmonary Atresia with IVS <input type="checkbox"/> Single Ventricle <input type="checkbox"/> TOF/DORV/RVOTO <input type="checkbox"/> Transposition of the Great Arteries <input type="checkbox"/> Truncus Arteriosus <input type="checkbox"/> VSD/ASD <input type="checkbox"/> Other _____
<input type="checkbox"/> Cardiomyopathy (if checked, complete below): <input type="checkbox"/> Dilated <input type="checkbox"/> Isolated/Idiopathic <input type="checkbox"/> Neuromuscular <input type="checkbox"/> Chemotherapy-induced <input type="checkbox"/> Familial <input type="checkbox"/> s/p Myocarditis <input type="checkbox"/> Metabolic/syndromic <input type="checkbox"/> Conduction defect <input type="checkbox"/> Ischemic, Kawasaki <input type="checkbox"/> Ischemic, Other _____ <input type="checkbox"/> ARVD <input type="checkbox"/> Other _____	<input type="checkbox"/> Hypertrophic (if checked, complete below): <input type="checkbox"/> Isolated/idiopathic <input type="checkbox"/> Metabolic/Syndromic <input type="checkbox"/> Neuromuscular <input type="checkbox"/> Familial <input type="checkbox"/> Other _____ <input type="checkbox"/> Restrictive (if checked, complete below): <input type="checkbox"/> Isolated/idiopathic <input type="checkbox"/> s/p Radiation <input type="checkbox"/> Chemotherapy-induced <input type="checkbox"/> Metabolic <input type="checkbox"/> Other _____ <input type="checkbox"/> Mixed <input type="checkbox"/> Other _____	<input type="checkbox"/> Cardiac Tumor <input type="checkbox"/> Isomerism <input type="checkbox"/> Ischemic, other _____ <input type="checkbox"/> Other, specify _____

10a. Cardiac Surgical History: Previous Surgery: <input type="checkbox"/> No (If no, skip to #11) <input type="checkbox"/> Yes (If yes, complete #10a-b) Total Number: _____ <input type="checkbox"/> Homograft: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Valve replacement: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify: <input type="checkbox"/> Tissue <input type="checkbox"/> Mechanical Choose Surgical Codes at right. Please list code and date of surgery (at least year) in chronological order.	10b. Code 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	Date _____ _____ _____ _____ _____ _____ _____ _____	Surgical Codes: 1. AP Shunt 2. ASD Repair 3. Complete AV Septal Defect Repair 4. Congenitally Corrected Transposition Repair 5. Damus Kaye Stansel (DKS) 6. Ebstein's Anomaly Repair 7. Fontan 8. Glenn, Bi-directional 9. PA Banding 10. TOF/DORV/RVOTO Repair 11. Transposition of the Great Vessels Repair 12. Truncus Arteriosus Repair 13. Valve Replacement or Repair for Outflow Obstruction 14. VSD Repair 15. Other, specify _____ 16. Other, specify _____ 17. Other, specify _____ 18. Other, specify _____ 19. Other, specify _____ 20. Other, specify _____ 21. Stage 1 Norwood – BT 22. Stage 1 Norwood – RV-PA conduit 23. Hybrid
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11. Status at Listing: <input type="checkbox"/> US <input type="checkbox"/> 1A <input type="checkbox"/> 1B <input type="checkbox"/> 2 <input type="checkbox"/> Other _____ <input type="checkbox"/> Canada _____ <input type="checkbox"/> UK _____ <input type="checkbox"/> Other _____ ABO incompatible: <input type="checkbox"/> No <input type="checkbox"/> Yes	Check All Status Details That Apply Per UNOS Policy 3.7 on 11/17/2009: <input type="checkbox"/> Status 1A, life expect <14 days <input type="checkbox"/> In Hospital <input type="checkbox"/> Out Hospital <input type="checkbox"/> ICU <input type="checkbox"/> IV Inotropes, high <input type="checkbox"/> IV Inotropes, low <input type="checkbox"/> Hemo Monitoring <input type="checkbox"/> Ventilator	<input type="checkbox"/> <6 mon old, pulmonary hypertension >50% systemic pressure <input type="checkbox"/> <6 mon old, pulmonary hypertension <50% systemic pressure <input type="checkbox"/> Growth failure due to acquired or congenital heart disease IF IABP VAD ECMO TAH, complete Mechanical Support Form (Form 15)
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PEDIATRIC HEART TRANSPLANT STUDY

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12. Infectious Disease Screening

GENERAL	HIV: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	IFA Toxo: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	RPR: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA
	CMV Serology: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	CMV PCR: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	Quant _____ DNA copies/mL
HEPAT	EBV Serology: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	EBV PCR: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	Quant _____ DNA copies/mL
	HBs Ag: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	HBs Ab: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	
	HB core Ab: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	Hep C Ab: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA	

13a. Blood Type, Patient: A (If known: A1 A2) B AB O **13b. Rh:** Pos Neg

14. Med Hx: (check all that apply) None

<input type="checkbox"/> Arrhythmia (check below)	<input type="checkbox"/> Dialysis – Acute	<input type="checkbox"/> Peripheral Myopathy
<input type="checkbox"/> Afib/flutter <input type="checkbox"/> V Tach <input type="checkbox"/> VFib	<input type="checkbox"/> Dialysis – Chronic	<input type="checkbox"/> Plastic Bronchitis
<input type="checkbox"/> Complete Ht Block	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Prenatal Diagnosis
<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Hepatitis: Dt dx: ____ (MO YR)	<input type="checkbox"/> Prior Transfusions
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension: Dt dx: ____	<input type="checkbox"/> Protein Losing Enteropathy
<input type="checkbox"/> CPR: Date Last ____ (MO YR)	<input type="checkbox"/> Malignancy, type: _____	<input type="checkbox"/> Renal Insufficiency
<input type="checkbox"/> CVA: Date Last ____	<input type="checkbox"/> Pacemaker: <input type="checkbox"/> BIV/CRT <input type="checkbox"/> AICD	<input type="checkbox"/> Shock: Date Last ____
<input type="checkbox"/> Diabetes	Date First Placed ____	<input type="checkbox"/> Other: _____

15. Primary Insurance: (check one)
 Medicaid (State HMO) Other Gov Private Self Donation Free Other _____

16. Percent or Panel Reactive Antibody (closest to listing): PRA, AHG_Enhanced: Yes No Unknown

16a. Cytotoxic PRA: Not Done T Cell _____% B Cell _____% Date: _____

16b. Cytotoxic PRA, DTE/DTT: Not Done T Cell _____% B Cell _____% Date: _____

16c. Flow PRA/Luminex: Not Done Class I _____% Class II _____% Date: _____

16d. ELISA: Not Done Class I _____% Class II _____% Date: _____

16e. Other: Specify Results, Methods and Units _____ Date: _____

16f. Specificities: Not Done A _____ B _____ DR _____
 Method used for specificities: Cytotoxic PRA Single Antigen Beads Date: _____

16g. Listed for prospective crossmatch: No Yes **If yes, specify:** donor cells virtual

17a. Hemodynamics closest to listing (Date ____):

BEST HEMODYNAMICS	BEST HEMODYNAMICS
Ram _____	Rp _____
PAm _____	Rs _____
PCW _____	AO Sat _____
C.O. _____	EDP _____
C.I. _____	SVC Sat _____
Qp/Qs _____	<input type="checkbox"/> Not Done

17b. Indicate agents for best hemodynamics

<input type="checkbox"/> None	<input type="checkbox"/> Nesiritide
<input type="checkbox"/> 100% O ₂	<input type="checkbox"/> Nitroglycerine
<input type="checkbox"/> Dopamine	<input type="checkbox"/> Nitroprusside (Nipride)
<input type="checkbox"/> Dobutamine	<input type="checkbox"/> Nitric Oxide
<input type="checkbox"/> Milrinone (Primacor)	<input type="checkbox"/> Others, specify: _____
<input type="checkbox"/> Isoproterenol (Isuprel)	_____
<input type="checkbox"/> PGE (Alprostadiol)	_____
<input type="checkbox"/> PGI (Flolan)	_____

18. Schooling:
 Within one grade level Delayed grade level Special education Not applicable, < 6 years Status unknown

19. Exercise Test:
 Not done
 Resting BP: ____ / ____
 HR: ____
 Max. duration: ____ min
 Max. BP: ____ / ____
 HR: ____
 % Predicted for Age: ____
 Max. VO₂ _____ ml/kg/mi

20. Laboratory Values: Date Performed (closest to listing) ____

(Print "NA" in spaces if not done)

Bili Total	Bili Direct	AST	ALT	BNP	CRP	Creat.	BUN/urea
T Protein	S Album	Cholesterol	TG	LDL	HDL	VLDL	

21. NYHA or Ross' Heart Failure: Not Done
 NYHA Class: I II III IV Ross' Heart Failure Class: I II III IV

Person completing this form: _____ Date original form mailed (do not send copy) _____

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