

PEDIATRIC HEART TRANSPLANT STUDY

FORM 03: 2010: Initial Immunosuppression & Antibiotics (PG 1 of 1)

To be filled out 30 days post-transplant

ID# P

P

Institutional Code

Sequential Patient Number

Patient Initials

Tran #

A. Initial Immunosuppression

1. Induction Therapy (cytolytic therapy soon after transplant not used to specifically treat known rejection):

No (If no, skip to # 2) Yes (If yes, complete this section)

Specifics of Induction; Indicate any dose or agent change on a new line:

AGENT*

Start Date

Stop Date

*Induction Agents:

ALG

ATG

Simulect (Basiliximab)

Zenapax (Daclizumab)

If other, please specify.

MO DAY YR

MO DAY YR

MO DAY YR

MO DAY YR

MO DAY YR

MO DAY YR

MO DAY YR

MO DAY YR

2. Azathioprine (Imuran):

Yes No

Daily dose at

If yes, date of first post-op dose: ____

30 days post transplant _____ mg/per day

PO IV

3. Cyclosporine:

Yes No

Daily dose at

If yes, date of first post-op dose: ____

30 days post transplant _____ mg/per day

PO IV

4. Mycophenolate (Cellcept, Myfortic):

Yes No

Daily dose at

If yes, date of first post-op dose: ____

30 days post transplant _____ mg/per day

PO IV

5. Sirolimus (Rapamycin):

Yes No

Daily dose at

If yes, date of first post-op dose: ____

30 days post transplant _____ mg/per day

PO IV

6. Tacrolimus (Prograf, FK506):

Yes No

Daily dose at

If yes, date of first post-op dose: ____

30 days post transplant _____ mg/per day

PO IV

7. Sterioids:

Pre-Operative Yes No

Intra-Operative Yes No

Post-Operative: Start Date: ____ (first post op dose)

Daily dose at 30 days _____ mg PO IV

Type at 30 days: Prednisone Prednisolone Solumedrol

Maintenance Sterioids:

Yes No If no, end date of steroid use ____

8. Other Immunosuppressants:

Yes No

If yes, specify: _____

If yes, date of first post op dose: ____

9. List and describe any unusual pre-op or early (1st 30 days) immunosuppression or procedures (including

plasmapheresis, photopheresis, immunoabsorption, or radiation (TLI) with dates): Desensitization strategies or anti-HLA therapies should be reported on Form 16: Anti-HLA Antibody.

B. Prophylactic Antibiotics/Antivirals started Pre-op through 30 days post op:

10. Infection Prophylaxis: Started during first 30 days post transplant (not used to treat a known infection):

Acyclovir (Zovirax)

Immune Globulin

Antifungal therapy, specify: _____

Trimethoprim | Sulfa

Cytogam

Other, specify: _____

Ganciclovir or Valganciclovir

11. Date of Hospital Discharge: ____

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