

# PEDIATRIC HEART TRANSPLANT STUDY

## FORM 08: 2010: Post Transplant Yearly Status Report (PG 1 of 1)

To be filled out post-transplant

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

1. Date of Follow-up: ( MO | DAY | YR )

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2a. Height:  in  cm      2b. Weight:  lb  kg

3. Hemodynamics:  Not done Date: \_\_\_ \_\_\_ \_\_\_

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

4. Current residence ZIP Code/Postal Code: \_\_\_\_\_

### 5. Patient Medical Care at time of this report: (complete a. OR b.)

a.  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 #6)
- Only yearly evaluation at our center, we do not follow PHTS events  
If only yearly evaluation, specify date PHTS event follow-up ceased \_\_\_ \_\_\_ \_\_\_

b.  Patient followed exclusively at another center: Specify date of last follow-up at your center \_\_\_ \_\_\_ \_\_\_

### 6. Medications:

- |   |  |
|---|--|
| <input type="checkbox"/> Antihypertensive         | <input type="checkbox"/> Prednisone            |
| <input type="checkbox"/> Antiviral prophylaxis    | <input type="checkbox"/> Sirolimus (Rapamycin) |
| <input type="checkbox"/> Azathioprine (Imuran)    | <input type="checkbox"/> Statin                |
| <input type="checkbox"/> Cyclosporine             | <input type="checkbox"/> Tacrolimus (Prograf)  |
| <input type="checkbox"/> Diuretic                 | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> MMF (Cellcept, Myfortic) |  |

### 7. Schooling:

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

### 8. Exercise Test:

- Not done
- Resting BP: \_\_\_ / \_\_\_
- HR: \_\_\_
- Max. duration: \_\_\_ min
- Max. BP: \_\_\_ / \_\_\_
- HR: \_\_\_
- % Predicted for Age: \_\_\_
- Max. VO<sub>2</sub> \_\_\_\_\_ ml/kg/mi

### 9. Additional Immunosuppressive Therapy: (Since Form 3 at 30 days post-transplant or last Form 08)

- Total Lymphoid Irrad: Total Dose \_\_\_ cGy     Plasmapheresis     Photopheresis     Other: \_\_\_\_\_

### 10. Primary Insurance: (check one)

- Medicaid ( State  HMO)     Other Gov     Private     Self     Donation     Free     Other \_\_\_\_\_

### 11. Laboratory: Date performed, (nearest this report due date): \_\_\_ \_\_\_ \_\_\_ (Print "NA" in spaces if not done)

Was lipid profile fasting:  Yes     No

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

### 12. Glomerular filtration rate (GFR)

12a. Method (check one):  Not Done (Skip to #13)     Nuclear medicine scan     12 or 24 hour urine collection  
 Calculated, specify method \_\_\_\_\_

12b. Result \_\_\_\_\_

13. Viral Studies: 13a. CMV Serology:  Pos  Neg  NA    CMV PCR:  Pos  Neg  NA    Quant \_\_\_\_\_ DNA copies/mL

13b. EBV Serology:  Pos  Neg  NA    EBV PCR:  Pos  Neg  NA    Quant \_\_\_\_\_ DNA copies/mL

### 14. Events: (since transplant or last Form 08)

- |   |   |   |
|---|---|---|
| Coronary Evaluation <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 04</i> | Coronary Revascularization <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 09</i>          | Dialysis<br><input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 14</i> |
| Rejection <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 05</i>           | Death <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 10</i>                               | Renal Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 14</i>  |
| Infection <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 06</i>           | Retransplantation <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Forms 01T, 02, 03, and 11</i> | Diabetes req. insulin <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Malignancy/LPD <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Form 07</i>      |   | 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, 2010