

PEDIATRIC HEART TRANSPLANT STUDY

FORM 10: 2010: Death (PG 1 of 1)

To be filled out for deaths while waiting or post-transplant

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

1. Date of Death: (MO | DAY | YR)

2. Primary Cause of Death (check only one):

- | | |
|--|---|
| <input type="checkbox"/> Accidental, specify: _____ | <input type="checkbox"/> Post-operative hemorrhage |
| <input type="checkbox"/> Anoxic insult | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Cerebrovascular accident | <input type="checkbox"/> Pulmonary hypertension/RV failure |
| <input type="checkbox"/> Coronary artery disease, (infarction, arrhythmia, CHF) | <input type="checkbox"/> Rejection, acute (complete Form 05) |
| <input type="checkbox"/> Fatal arrhythmia | <input type="checkbox"/> Rejection, hyperacute (onset < 24 hours post transplant) |
| <input type="checkbox"/> Infection (complete Form 06) | <input type="checkbox"/> Respiratory failure |
| <input type="checkbox"/> Lymphoma/Lymphoproliferative disease (complete Form 07) | <input type="checkbox"/> Sudden cardiac death, no MI documented |
| <input type="checkbox"/> Malignancy, non-lymphoma (complete Form 07) | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Poor donor preservation | <input type="checkbox"/> Unknown |
| | <input type="checkbox"/> Other, specify: _____ |

3. Contributing causes of Death (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Accidental, specify: _____ | <input type="checkbox"/> Poor donor preservation |
| <input type="checkbox"/> Anoxic insult | <input type="checkbox"/> Post-operative hemorrhage |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Cerebrovascular accident | <input type="checkbox"/> Pulmonary hypertension/RV failure |
| <input type="checkbox"/> Coronary artery disease, (infarction, arrhythmia, CHF) | <input type="checkbox"/> Rejection, acute (complete Form 05) |
| <input type="checkbox"/> Infection (complete Form 06) | <input type="checkbox"/> Rejection, hyperacute (onset < 24 hours post transplant) |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Renal failure |
| <input type="checkbox"/> Lymphoma/Lymphoproliferative disease (complete Form 07) | <input type="checkbox"/> Sudden cardiac death, no MI documented |
| <input type="checkbox"/> Malignancy, non-lymphoma (complete Form 07) | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Noncompliance | <input type="checkbox"/> Unknown |
| | <input type="checkbox"/> Other, specify: _____ |

4. Patient supported by IABP/VAD/TAH/ECMO at time of death? No Yes If yes, complete Form 15

5a. If patient transplanted, was the patient relisted prior to death?

No Yes If yes, date listed: ____ ____ ____

5b. If listed for transplant at death:

Status at Death:

- US 1A 1B 2
 Other _____

Canada _____

UK _____

Other _____

ABO incompatible: No 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"/> <6 mon old, pulmonary hypertension >50% systemic pressure |
| <input type="checkbox"/> In Hospital | <input type="checkbox"/> <6 mon old, pulmonary hypertension <50% systemic pressure |
| <input type="checkbox"/> Out Hospital | <input type="checkbox"/> Growth failure due to acquired or congenital heart disease |
| <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 | |
- If IABP VAD ECMO TAH, complete Mechanical Support Form (Form 15)**

5c. History of PRA > 10% No Yes

6. Post Mortem Examination (autopsy)? No Yes If yes: cardiac pathology found (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Acute rejection: (ACR: _____, AMR: _____) | <input type="checkbox"/> No cardiac pathology found |
| <input type="checkbox"/> CAD, remote infarction (>1wk) | <input type="checkbox"/> Diffuse fibrosis, no acute rejection |
| <input type="checkbox"/> Coronary artery disease, recent infarction (≤ 1 wk) | <input type="checkbox"/> Graft atherosclerosis |
| | <input type="checkbox"/> Other, specify: _____ |

7. Comments or special circumstances surrounding death (attach copy of autopsy and death summary with any identifiable patient information removed. Be sure to include PHTS patient number and initials): _____

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