

# PEDIATRIC HEART TRANSPLANT STUDY

## FORM 11: 2010: Re-Transplantation (PG 1 of 1)

To be filled out post-transplant

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

**COMPLETE FORMS 1T, 02, AND 03 FOR RE-TRANSPLANT. DO NOT COMPLETE FORM 01 FOR RE-TRANSPLANTATION.**

**1. Date of Re-Transplantation:**        
(MO | DAY | YR)

**2. Primary Reason for Re-Transplantation (check only one):**

- |   |   |
|---|---|
| <input type="checkbox"/> Coronary artery disease, (infarction, arrhythmia, CHF post MI) | <input type="checkbox"/> Rejection, hyperacute (onset < 24 hours post transplant) |
| <input type="checkbox"/> Non-specific graft failure (>30 days post transplant)          | <input type="checkbox"/> Sudden cardiac death, no MI documented                   |
| <input type="checkbox"/> Pulmonary Hypertension/RV Failure                              | <input type="checkbox"/> Other, specify: _____                                    |
| <input type="checkbox"/> Rejection, acute (complete Form 05)                            |   |

**3. Contributing Reasons for Re-Transplantation (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Coronary artery disease, (infarction, arrhythmia, CHF post MI) | <input type="checkbox"/> Rejection, acute (complete Form 05)                      |
| <input type="checkbox"/> Non-compliance   | <input type="checkbox"/> Rejection, hyperacute (onset < 24 hours post transplant) |
| <input type="checkbox"/> Non-specific graft failure (> 30 days post transplant)         | <input type="checkbox"/> Sudden cardiac death, no MI documented                   |
| <input type="checkbox"/> Pulmonary Hypertension/RV Failure                              | <input type="checkbox"/> Other, specify: _____                                    |

**4. Date of Re-Listing:** \_\_\_\_ \_\_\_\_ \_\_\_\_

**5. Status at Re-Listing:**

- 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                             | <b>If IABP VAD ECMO TAH, complete Mechanical Support Form (Form 15)</b>             |
| <input type="checkbox"/> IV Inotropes, high              |   |
| <input type="checkbox"/> IV Inotropes, low               |   |
| <input type="checkbox"/> Hemo Monitoring                 |   |
| <input type="checkbox"/> Ventilator                      |   |

**6. Pathology of Explanted Heart:**    No    Yes   If yes: cardiac allograft 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 regarding re-transplantation:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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