

PEDIATRIC HEART TRANSPLANT STUDY

FORM 16: 2010: Anti-HLA Antibodies (PG 1 of 1)

To be completed at time of transplant or death waiting (for patients with a PRA greater than 10% or a positive donor specific crossmatch)

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

1. Time of this report Transplant Death while waiting

2. Reason for report PRA > 10% Positive donor specific crossmatch

3. Pre-transplant interventions for elevated PRA

a. Did the patient receive treatment to lower or manage an elevated PRA while awaiting transplantation?

No (skip to #2) Yes (if yes, complete b. and c.)

b. Which therapy was administered?

	Frequency	Duration
<input type="checkbox"/> Immunoglobulin	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	_____
<input type="checkbox"/> MMF (Cellcept, Myfortic)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	_____
<input type="checkbox"/> Azathioprine (Imuran)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	_____
<input type="checkbox"/> Plasmapheresis	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	_____
<input type="checkbox"/> Cytoxan	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	_____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	_____

c. How long was therapy administered?

- i. Until heart transplantation, regardless of subsequent PRA levels
- ii. Until PRA level reduced below prespecified number, specify: _____
- iii. Until PRA level reduced to 0%
- iv. For a prespecified time only, specify: _____

4. Peri-operative management for elevated PRA

a. Was prophylactic plasmapheresis performed in the peri-operative period? Yes No

b. If yes, was this performed during cardiopulmonary bypass? Yes No

c. If yes, was this performed in the immediate post-operative period? Yes No

If yes, how many cycles: _____

d. Were additional therapies, not routinely administered to post-transplant patients, given to this patient:

- Yes No
- If yes: Immunoglobulin
- MMF (Cellcept, Myfortic)
- Azathioprine (Imuran)
- Plasmapheresis
- Cytoxan
- Other: _____

Person completing this form: _____

Date original form mailed (do not send copy) _____