PEDIATRIC HEART TRANSPLANT STUDY

FORM 01: 2010: **Initial Patient Entry at Listing** (PG 1 of 2)
To be filled out at time of listing

ID# **P** ☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐

P | Instituitional Code | Sequential Patient Number | Patient Initials | Tran #

1. Institution Code: ___ ___ ___

2. Patient Number: ___ ___ ___ ___

3. Patient Initials: ___ ___ ___

4. Height: _____ ☐ in ☐ cm **Weight:** _____ ☐ lb ☐ kg

5. Date of Birth: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

6. Date of Listing: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

7. Gender: ☐ Male ☐ Female

8a. Race: **(See Manual, check all that apply)**

- ☐ White
- ☐ Black
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Pacific Islander
- ☐ Mid-east/Arabian
- ☐ Indian Subcontinent
- ☐ Other, specify: _____

8b. Hispanic Origin:

- ☐ Yes
- ☐ No

9. Etiology: **(Choose only ONE primary etiology)**

- ☐ **Myocarditis**
- ☐ **Cardiomyopathy** (if checked, complete below):
  - ☐ Dilated
    - ☐ Isolated/Idiopathic
    - ☐ Neuromuscular
    - ☐ Chemotherapy-induced
    - ☐ Familial
    - ☐ s/p Myocarditis
    - ☐ Metabolic/syndromic
    - ☐ Conduction defect
    - ☐ Ischemic, Kawasaki
    - ☐ Ischemic, Other _____
    - ☐ ARVD
    - ☐ Other _____

(Cardiomyopathy continued)

- ☐ Hypertrophic (if checked, complete below):
  - ☐ Isolated/idiopathic
  - ☐ Metabolic/Syndromic
  - ☐ Neuromuscular
  - ☐ Familial
  - ☐ Other _____
- ☐ Restrictive (if checked, complete below):
  - ☐ Isolated/idiopathic
  - ☐ s/p Radiation
  - ☐ Chemotherapy-induced
  - ☐ Metabolic
  - ☐ Other _____
- ☐ Mixed
- ☐ Other _____

- ☐ **Congenital Heart Disease** (if checked, complete below):
  - ☐ Complete AV Septal Defect
  - ☐ Congenitally Corrected Transposition
  - ☐ Ebstein's Anomaly
  - ☐ Hypoplastic Left Heart
  - ☐ Left Heart Valvar/Structural Hypoplasia
  - ☐ Pulmonary Atresia with IVS
  - ☐ Single Ventricle
  - ☐ TOF/DORV/RVOTO
  - ☐ Transposition of the Great Arteries
  - ☐ Truncus Arteriosus
  - ☐ VSD/ASD
  - ☐ Other _____
- ☐ **Cardiac Tumor**
- ☐ **Isomerism**
- ☐ **Ischemic, other** _____
- ☐ **Other, specify** _____

10a. Cardiac Surgical History:

Previous Surgery:

- ☐ No **(If no, skip to #11)**
- ☐ Yes **(If yes, complete #10a-b)**

Total Number: _____

- ☐ Homograft: ☐ No ☐ Yes
- ☐ Valve replacement: ☐ No ☐ Yes

If yes, please specify:

- ☐ Tissue ☐ Mechanical

Choose **Surgical Codes** *at right. Please list code and date of surgery (at least year) in chronological order.*

10b. Code	**Date**
1. ___	___ ___ ___
2. ___	___ ___ ___
3. ___	___ ___ ___
4. ___	___ ___ ___
5. ___	___ ___ ___
6. ___	___ ___ ___
7. ___	___ ___ ___
8. ___	___ ___ ___

Surgical Codes:

1. AP Shunt
2. ASD Repair
3. Complete AV Septal Defect Repair
4. Congenitally Corrected Transposition Repair
5. Damus Kaye Stansel (DKS)
6. Ebstein's Anomaly Repair
7. Fontan
8. Glenn, Bi-directional
11. PA Banding
12. TOF/DORV/RVOTO Repair
13. Transposition of the Great Vessels Repair
14. Truncus Arteriosus Repair
15. Valve Replacement or Repair for Outflow Obstruction
16. VSD Repair
17. Other, specify _____
18. Other, specify _____
19. Other, specify _____
20. Other, specify _____
21. Stage 1 Norwood – BT
22. Stage 1 Norwood – RV-PA conduit
23. Hybrid

11. Status at 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:

- ☐ Status 1A, life expect <14 days
- ☐ In Hospital
- ☐ Out Hospital
- ☐ ICU
- ☐ IV Inotropes, high
- ☐ IV Inotropes, low
- ☐ Hemo Monitoring
- ☐ Ventilator
- ☐ <6 mon old, pulmonary hypertension >50% systemic pressure
- ☐ <6 mon old, pulmonary hypertension <50% systemic pressure
- ☐ Growth failure due to acquired or congenital heart disease

If IABP VAD ECMO TAH, complete Mechanical Support Form (Form 15)

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PEDIATRIC HEART TRANSPLANT STUDY

FORM 01: 2010: **Initial Patient Entry at Listing** (PG 2 of 2)
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ID# **P** ☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐

P	Instituitional Code	Sequential Patient Number	Patient Initials	Tran #

12. Infectious Disease Screening

GENERAL
HIV: ☐ Pos ☐ Neg ☐ NA IFA Toxo: ☐ Pos ☐ Neg ☐ NA RPR: ☐ Pos ☐ Neg ☐ NA
CMVSerology: ☐ Pos ☐ Neg ☐ NA CMV PCR: ☐ Pos ☐ Neg ☐ NA Quant _____ DNA copies/mL
EBV Serology: ☐ Pos ☐ Neg ☐ NA EBV PCR: ☐ Pos ☐ Neg ☐ NA Quant _____ DNA copies/mL

HEPAT
HBs Ag: ☐ Pos ☐ Neg ☐ NA HBs Ab: ☐ Pos ☐ Neg ☐ NA
HB core Ab: ☐ Pos ☐ Neg ☐ NA Hep C Ab: ☐ Pos ☐ Neg ☐ NA

13a. Blood Type, Patient**:** ☐ A (If known: ☐ A1 ☐ A2) ☐ B ☐ AB ☐ O **13b. Rh:** ☐ Pos ☐ Neg

14. Med Hx: **(check all that apply)** ☐ None

- ☐ Arrhythmia (check below)
  - ☐ Afib/flutter ☐ V Tach ☐ VFib
  - ☐ Complete Ht Block
  - ☐ Other, specify: _____
- ☐ Asthma
- ☐ CPR: Date Last ___ ___ (MO|YR)
- ☐ CVA: Date Last ___ ___
- ☐ Diabetes
- ☐ Dialysis – Acute
- ☐ Dialysis – Chronic
- ☐ Failure to thrive
- ☐ Hepatitis: Dt dx: ___ ___ (MO|YR)
- ☐ Hypertension: Dt dx: ___ ___
- ☐ Malignancy, type: _____
- ☐ Pacemaker: ☐ BIV/CRT ☐ AICD
  Date First Placed ___ ___
- ☐ Peripheral Myopathy
- ☐ Plastic Bronchitis
- ☐ Prenatal Diagnosis
- ☐ Prior Transfusions
- ☐ Protein Losing Enteropathy
- ☐ Renal Insufficiency
- ☐ Shock: Date Last ___ ___
- ☐ Other: _____

15. Primary Insurance: **(check one)**
Medicaid (☐ State ☐ HMO) ☐ Other Gov ☐ Private ☐ Self ☐ Donation ☐ Free ☐ Other _____

16. Percent or Panel Reactive Antibody (closest to listing)**:** PRA, AHG_Enhanced: ☐ Yes ☐ No ☐ Unknown

16a. Cytotoxic PRA:	☐ Not Done	T Cell	_____ %	B Cell	_____ %	Date:	___ ___ ___
16b. Cytotoxic PRA, DTE/DTT:	☐ Not Done	T Cell	_____ %	B Cell	_____ %	Date:	___ ___ ___
16c. Flow PRA/Luminex:	☐ Not Done	Class I	_____ %	Class II	_____ %	Date:	___ ___ ___
16d. ELISA:	☐ Not Done	Class I	_____ %	Class II	_____ %	Date:	___ ___ ___

16e. Other: Specify Results, Methods and Units ☐ Not Done _____ Date: ___ ___ ___

16f. Specificities: ☐ Not Done A _____ B _____ DR _____
Method used for specificities: ☐ Cytotoxic PRA ☐ Single Antigen Beads Date: ___ ___ ___

16g. Listed for prospective crossmatch: ☐ No ☐ Yes **If yes, specify:** ☐ donor cells ☐ virtual

17a. Hemodynamics closest to listing (Date ___ ___ ___):

BEST HEMODYNAMICS		BEST HEMODYNAMICS	
Ram	_____	Rp	_____
PAm	_____	Rs	_____
PCW	_____	AO Sat	_____
C.O.	_____	EDP	_____
C.I.	_____	SVC Sat	_____
Qp/Qs	_____	☐ Not Done	

17b. Indicate agents for best hemodynamics

- ☐ None
- ☐ 100% O_2
- ☐ Dopamine
- ☐ Dobutamine
- ☐ Milrinone (Primacor)
- ☐ Isoproterenol (Isuprel)
- ☐ PGE (Alprostadil)
- ☐ PGI (Flolan)
- ☐ Nesiritide
- ☐ Nitroglycerine
- ☐ Nitroprusside (Nipride)
- ☐ Nitric Oxide
- ☐ Others, specify:
  _____
  _____
  _____

18. Schooling:
☐ Within one grade level ☐ Delayed grade level ☐ Special education ☐ Not applicable, < 6 years ☐ Status unknown

19. Exercise Test:
☐ Not done
Resting BP: ___ / ___
HR: ___
Max. duration: ___ min
Max. BP: ___ / ___
HR: ___
% Predicted for Age: ___
Max. VO_2 _____ ml/kg/mi

20. Laboratory Values: Date Performed (closest to listing) ___ ___ ___
(Print "NA" in spaces if not done)

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

21. NYHA or Ross' Heart Failure: ☐ Not Done
NYHA Class: ☐ I ☐ II ☐ III ☐ IV Ross' Heart Failure Class: ☐ I ☐ II ☐ III ☐ IV

Person completing this form: _____ Date original form mailed (do not send copy) _____

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