

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