Adult Kidney Transplant Recipient Registration Worksheet

Note: These worksheets are provided to function as a guide to what data will be required in the online TIEDI® application. Currently in the worksheet, a red asterisk is displayed by fields that are required, independent of what other data may be provided. Based on data provided through the online TIEDI® application, additional fields that are dependent on responses provided in these required fields may become required as well. However, since those fields are not required in every case, they are not marked with a red asterisk.

Recipient Information		
Name:	DOB:	
SSN:	Birth	sex:
HIC:	Trans Time	splant Date and
	Time	:
State of Permanent Residence: *		
Permanent Zip: *	-	
Provider Information Recipient Center:		
•		
Surgeon Name: *		
NPI#:*		
Donor Information		
UNOS Donor ID #:		
Recovering OPO:		
Donor Type:		
Patient Status		
Primary Diagnosis: *		
Specify:		
Date: Last Seen, Retransplanted or Death*		
Patient Status: *	CLIVING	
	DEAD	
	RETRANSPLANTED	
Primary Cause of Death:		
Specify:		
эреспу.		
Contributory Cause of Death:		
Specify:		
Contributory Cause of Death:		
Specify:		
эреспу.		
Transplant Hospitalization:		
Date of Admission to Tx Center:*		
Date of Discharge from Tx Center:		
Clinical Information : PRETRANS Functional Status: *	PLANT	
Working for income: *	YES NO UNK	
Source of Payment:		
Primary: *		
Specify:		
Height: ∗	ft. in.	cm ST=
Weight:*		
	lbs	kg ST=
BMI:	kg/m ²	
Previous Transplants:		
Previous Transplant Organ	Previous Transplant Date	Previous Transplant Graft Fail Date
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Pretransplant Dialysis: *	YES NO UNK	
If Yes, Date of Most Recent Initiation of Chronic Maintenance Dialysis:		ST=
Serum Creatinine at Time of Tx: *	mg/dl	ST=
/iral Detection:	37.	
HIV Serostatus:*	Positive	
	Negative	
	Not Done	
	OUNK/Cannot Disclose	
CMV Status*	Positive	
	Negative	
	Not Done	
	OUNK/Cannot Disclose	
HBV Surface Antibody Total ∗	Positive	
	ONegative	
	Not Done	
	OUNK/Cannot Disclose	
HBV Core Antibody: *	OPositive	
	ONegative	
	Not Done	
	OUNK/Cannot Disclose	
HBV Surface Antigen: *	Positive	
	ONegative	
	ONot Done	
	OUNK/Cannot Disclose	
HCV Serostatus: *	Positive	
They selected as the	ONegative	
	ONot Done	
	OUNK/Cannot Disclose	
EBV Serostatus: *		
EDV Serosidius. A	Positive	
	Negative Not Done	
	OUNK/Cannot Disclose	
for adjusting Chature	ONK/ Calliot Disclose	
/accination Status: Did the recipient receive Hepatitis B vaccines prior to	YES ONO OUNK	
transplant?:*	YES OND OUNK	
Reason not vaccinated:	Immunity	
	OMedical precaution	
	Time constraints	
	Patient objection	
	Product out of stock	
	Other, specify	
Specify:		
NAT Results:		

Negative Not Done UNK/Cannot Disclose	HIV NAI:*	○ Positive
HBV NAT: * Positive Negative Not bone UWK/Cannot Disclose		Negative
Positive Negative		Not Done
Negative Not Done UNK/Cannot Disclose Previous Pregnancies: Previous Previ		OUNK/Cannot Disclose
Not Done UNK/Cannot Disclose Positive Negative Not Done UNK/Cannot Disclose Previous Pregnancies: YES NO NOT APPLICABLE: < 10 years old Malignancies between listing and transplant: * YES NO NOT APPLICABLE: < 10 years old Malignancies between listing and transplant: * YES NO This question is NOT applicable for patients receiving living donor transplants who were never on the walting list. If yes, specify type: Skin Melanoma CKNS Tumor Genitourinary Breast Thyroid Transpue/Throat/Larynx Lung Leukemia / Lymphoma Liver Oother, specify Specify: Clinical Information: TRANSPLANT PROCEDURE Multiple Organ Recipient Were extra vessels used in the transplant procedure: Procedure Type: Kidney Preservation Information: Total Cold ischemia Time Rejink KI(OR EN-BLOC): (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time): Total Cold ischemia Time Left KI (if pumped, include pump time):	HBV NAT:∗	Positive
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Skin Non-Melanoma CNS Tumor Genitourinary Breast Thyroid Trongue/Throat/Larynx Lung Leukemia/Lymphoma Liver Other, specify		_
CNS Tumor Genitourinary	If yes, specify type:	
Genitourinary Breast Trhyroid Trongue/Throat/Larynx Lung Lung Lung Lung Lung Ceukemia/Lymphoma Liver Other, specify		Skin Non-Melanoma
Breast Thyroid Trongue/Throat/Larynx Lung Lung Luver Other, specify Specify: Clinical Information : TRANSPLANT PROCEDURE Multiple Organ Recipient Were extra vessels used in the transplant procedure: Procedure Type: Kidney Preservation Information: Total Cold ischemia Time Right KI (if pumped, include pump time): Kidney (s) received on: * Ice Pump N/A Received on lice: Stayed on pump Received on pump: Stayed on pump Put on ice		□CNS Tumor
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If put on pump or stayed on pump:
Right Kidney Final resistance at transplant:
Right Kidney Final flow rate at transplant:
Left Kidney Final resistance at transplant:
Organ Check-in Information:
Left Kidney Date: Time: Military time Time Zone: ST= Check-In Date
and Time:
Right Kidney Date: Time: Military time Time Zone: ST= Check-In Date and Time:
En Bloc Kidneys Date: Military time Time Zone: ST= Check-In Date
and Time:
Clinical Information : POST TRANSPLANT
Graft Status:* Functioning Failed
_
If death is indicated for the recipient, and the death was a result of some other factor unrelated to graft failure, select Functioning. Resumed Maintenance Dialysis: YES NO
Date Maintenance Dialysis Resumed:
Date of Graft Failure:
Primary Cause of Graft Failure: HYPERACUTE REJECTION
OACUTE REJECTION
PRIMARY NON-FUNCTION (GRAFT NEVER FUNCTIONED POST-TRANSPLANT)
GRAFT THROMBOSIS
INFECTION
SURGICAL COMPLICATIONS
UROLOGICAL COMPLICATIONS
ORECURRENT DISEASE OTHER SPECIFY CAUSE
Specify:
Most Recent Serum Creatinine Prior to Discharge: * mg/dl ST=
Patient Need Dialysis within First Week: * YES ONO
Did patient have any acute rejection episodes between transplant and discharge: *
Yes, none treated with additional anti-rejection agent
ONo
Immunosuppressive Information Are any medications given currently for maintenance or anti-rejection: *
Immunosuppressive Medications
View Immunosuppressive Medications
Definitions Of Immunosuppressive Medications
For each of the immunosuppressive medications listed, select Ind (Induction), Maint (Maintenance) or AR (Anti-rejection) to indicate all medications that were prescribed for the recipient during the initial transplant hospitalization period, and for what reason. If a medication was not given, leave the associated box(es) blank.
Induction (Ind) immunosuppression includes all medications given for a short finite period in the perioperative period for the purpose of preventing acute rejection. Though the drugs may be continued after discharge for the first 30 days after transplant, it will not be used long-term for immunosuppressive maintenance. Induction agents are usually polyclonal, monoclonal, or IL-2 receptor antibodies (example: methylprednisolone, Campath, Thymoglobulin, or Simulect). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as anti-rejection therapy if used for this reason. For each induction medication indicated, write the total number of days the drug was actually administered in the space provided. For example, if Simulect was given in 2 doses a week apart then the total number of days would be 2, even if the second dose was given after the patient was discharged. Maintenance (Maint) includes all immunosuppressive medications given before, during or after transplant with the intention to maintain them long-term (example: prednisone, cyclosporine, tacrolimus, mycophenolate mofetil, azathioprine, or Rapamune). This does not include any immunosuppressive medications given to treat rejection episodes, or for induction.

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Anti-rejection (AR) immunosuppression includes all immunosuppressive medications given for the purpose of treating an acute rejection episode during the initial post-transplant period or during a specific follow-up period, usually up to 30 days after the diagnosis of acute rejection (example: methylprednisolone, or Thymoglobulin). When switching maintenance drugs (example: from tacrolimus to cyclosporine; or from mycophenolate mofetil to azathioprine) because of rejection, the drugs should not be listed under AR immunosuppression, but should be listed under maintenance immunosuppression.

If an immunosuppressive medication other than those listed is being administered (e.g., new monoclonal antibodies), select Ind, Maint, or AR next to Other Immunosuppressive Medication field, and enter the full name of the medication in the space provided. **Do not list non-immunosuppressive medications.**

Drug used for induction, acute rejection, or maintenance	Ind.	Days	ST	Maint	AR
Steroids (prednisone, methylprednisolone, Solumedrol, Medrol)		Days			
Drugs used for induction or acute rejection					
Atgam	Ind.	Days	ST	Maint	AR
Campath (alemtuzumab)					
Cytoxan (cyclophosphamide)					
Methotrexate (Folex PFS, Mexate-AQ, Rheumatrex)					
Rituxan (rituximab)					
Simulect (basiliximab)					
Thymoglobulin					
Drugs primarily used for maintenance					
Cyclosporine, select from the following:	Ind.	Days	ST	Maint	AR
- Gengraf					
- Neoral					
- Sandimmune					
- Generic cyclosporine					
Imuran (azathioprine, AZA)					
Leflunomide (LFL)					
Mycophenolic acid, select from the following:					
- CellCept (MMF)					
- Generic MMF (generic CellCept)					
- Myfortic (mycophenolic acid)					
- Generic Myfortic (generic mycophenolic acid)					
mTOR inhibitors, select from the following:					
- Rapamune (sirolimus)					
- Generic sirolimus					
- Zortress (everolimus)					
Nulojix (belatacept)					
Tacrolimus, select from the following:					
- Astagraf XL (extended release tacrolimus)					
- Envarsus XR (tacrolimus XR)					
- Prograf (tacrolimus)					
- Generic tacrolimus (generic Prograf)					

Other immunosuppressive medication, specify:		Ind.	Days	ST	Maint	AR
Other immunosuppressive medication, specify:	Other immunosuppressive medication, specify:					
	Other immunosuppressive medication, specify:					

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