

Adult Thoracic - Lung Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 08/31/2023

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:	<input type="text"/>	DOB:	<input type="text"/>
SSN:	<input type="text"/>	Gender:	<input type="text"/>
HIC:	<input type="text"/>	Tx Date:	<input type="text"/>
State of Permanent Residence: *	<input type="text"/>		
Permanent Zip: *	<input type="text"/>	-	<input type="text"/>

Provider Information

Recipient Center:	<input type="text"/>
Physician Name: *	<input type="text"/>
Physician NPI#: *	<input type="text"/>
Surgeon Name: *	<input type="text"/>
Surgeon NPI#: *	<input type="text"/>

Donor Information

UNOS Donor ID #:	<input type="text"/>
Recovering OPO:	<input type="text"/>
Donor Type:	<input type="text"/>

Patient Status

Primary Diagnosis: *	<input type="text"/>
Specify:	<input type="text"/>
Date: Last Seen, Retransplanted or Death *	<input type="text"/>
Patient Status: *	<input type="radio"/> LIVING <input type="radio"/> DEAD <input type="radio"/> RETRANSPLANTED
Primary Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Contributory Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Contributory Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Transplant Hospitalization:	
Date of Admission to Tx Center: *	<input type="text"/>
Date of Discharge from Tx Center:	<input type="text"/>

Clinical Information : PRETRANSPLANT

Medical Condition at time of transplant: *	<input type="radio"/> IN INTENSIVE CARE UNIT <input type="radio"/> HOSPITALIZED NOT IN ICU <input type="radio"/> NOT HOSPITALIZED
Patient on Life Support: *	<input type="radio"/> YES <input type="radio"/> NO

Specify: Intra Aortic Balloon Pump
 Prostacyclin Infusion
 Prostacyclin Inhalation
 Inhaled NO
 Ventilator
 Other Mechanism

Functional Status:*

Working for income:* YES NO UNK

Source of Payment:
Primary:*
Specify:

Height:* ft. in. cm **ST=**

Weight:* lbs kg **ST=**

BMI: kg/m²

Previous Transplants:

Previous Transplant Organ	Previous Transplant Date	Previous Transplant Graft Fail Date

The three most recent transplants are listed here. Please contact the UNet Help Desk to confirm more than three previous transplants by calling 800-978-4334 or by emailing unethelpdesk@unos.org.

Viral Detection:

HIV Serostatus:* Positive
 Negative
 Not Done
 UNK/Cannot Disclose

CMV Status* Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HBV Surface Antibody Total* Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HBV Core Antibody: * Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HBV Surface Antigen: * Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HCV Serostatus: * Positive
 Negative
 Not Done
 UNK/Cannot Disclose

EBV Serostatus: * Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HIV NAT: *	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/ Cannot Disclose
HBV NAT: *	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/ Cannot Disclose
HCV NAT: *	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/ Cannot Disclose

Most Recent Hemodynamics:		Inotropes/Vasodilators:	
PA (sys)mm/Hg: *	<input type="text"/>	ST= <input type="checkbox"/>	<input type="radio"/> YES <input type="radio"/> NO
PA(dia) mm/Hg: *	<input type="text"/>	ST= <input type="checkbox"/>	<input type="radio"/> YES <input type="radio"/> NO
PA(mean) mm/Hg: *	<input type="text"/>	ST= <input type="checkbox"/>	<input type="radio"/> YES <input type="radio"/> NO
PCW(mean) mm/Hg: *	<input type="text"/>	ST= <input type="checkbox"/>	<input type="radio"/> YES <input type="radio"/> NO
CO L/min: *	<input type="text"/>	ST= <input type="checkbox"/>	<input type="radio"/> YES <input type="radio"/> NO

Most Recent Serum Creatinine: *	<input type="text"/> mg/dl	ST= <input type="checkbox"/>
Most Recent Total Bilirubin: *	<input type="text"/> mg/dl	ST= <input type="checkbox"/>
Chronic Steroid Use: *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK	
Pulmonary Status (Give most recent value):		
FVC: *	<input type="text"/> %predicted:	ST= <input type="checkbox"/>
FeV1: *	<input type="text"/> %predicted:	ST= <input type="checkbox"/>
pCO2: *	<input type="text"/> mm/Hg:	ST= <input type="checkbox"/>

Events occurring between listing and transplant:

Transfusions: * YES NO UNK

Infection Requiring IV Therapy within 2 wks prior to Tx: * YES NO UNK

Dialysis: * YES NO UNK

Prior Cardiac Surgery (non-transplant): * YES NO UNK

CABG
 Valve Replacement/Repair
 Congenital
 Left Ventricular Remodeling
 Other, specify

If yes, check all that apply:

Specify:

Prior Lung Surgery (non-transplant): * YES NO UNK

If yes, check all that apply:

Pneumothorax Surgery-Nodule
Pneumothorax Decortication
Lobectomy
Pneumonectomy
Left Thoracotomy
Right Thoracotomy
Other, specify

Specify:

Episode of Ventilatory Support: * YES NO UNK

If yes, indicate most recent timeframe: At time of transplant
Within 3 months of transplant
>3 months prior to transplant

Tracheostomy: * YES NO UNK

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Type:

SINGLE LEFT LUNG
SINGLE RIGHT LUNG
BILATERAL SEQUENTIAL LUNG
EN-BLOC DOUBLE LUNG
LOBE, RIGHT
LOBE, LEFT

Total Organ Preservation Time From Cross Clamp to In Situ Reperfusion (include warm and cold time):

Left Lung: min **ST=**

Right Lung (OR EN-BLOC): min **ST=**

Lung(s) perfused prior to transplant? YES NO

Perfusion occurred at:

Recovery Site (donor hospital)
OPO
Transplant hospital - transplant site
Transplant hospital - not transplant site
External perfusion center
OPO

Perfusion performed by:

Transplant Program
External perfusion center

Total time on perfusion: min **ST=**

Left lung received at transplant center:

Received at center on ice
Received at center on pump, stayed on pump
Received at center on pump, put on ice
Received at center on ice

Right lung received at transplant center:

Received at center on pump, stayed on pump
Received at center on pump, put on ice
Received at center on ice

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.

Primary Cause of Graft Failure:

Specify:

Events Prior to Discharge:

Stroke: * YES NO UNK

Dialysis: * YES NO UNK

Ventilator Support: *

No

Ventilator support for <= 48 hours

Ventilator support for >48 hours but < 5 days

Ventilator support >= 5 days

Ventilator support, duration unknown

Unknown Status

Reintubated: * YES NO UNK

Permanent Pacemaker: * YES NO UNK

Components of ISHLT primary graft dysfunction (PGD) grade

Intubated at 72 hours * YES NO UNK

PaO2 at 72 Hours * mm/Hg ST=

FiO2 at 72 Hours * % ST=

ECMO at 72 hours * YES NO UNK

Inhaled NO at 72 hours * YES NO UNK

Airway Dehiscence: * YES NO UNK

Did patient have any acute rejection episodes between transplant and discharge: *

Yes, at least one episode treated with anti-rejection agent

Yes, none treated with additional anti-rejection agent

No

Immunosuppressive Information

Are any medications given currently for maintenance or anti-rejection: * YES NO

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.

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)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Candidate Name: DOB:

	Ind.	Days	ST	Maint	AR
Atgam	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campath (alemtuzumab)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytoxan (cyclophosphamide)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Folex PFS, Mexate-AQ, Rheumatrex)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rituxan (rituximab)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simulect (basiliximab)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thymoglobulin	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drugs primarily used for maintenance

	Ind.	Days	ST	Maint	AR
Cyclosporine, select from the following:					
- Gengraf	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Neoral	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Sandimmune	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic cyclosporine	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imuran (azathioprine, AZA)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leflunomide (LFL)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mycophenolic acid, select from the following:					
- CellCept (MMF)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic MMF (generic CellCept)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Myfortic (mycophenolic acid)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic Myfortic (generic mycophenolic acid)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mTOR inhibitors, select from the following:					
- Rapamune (sirolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic sirolimus	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Zortress (everolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nulojix (belatacept)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tacrolimus, select from the following:					
- Astagraf XL (extended release tacrolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Envarsus XR (tacrolimus XR)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Prograf (tacrolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic tacrolimus (generic Prograf)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other drugs

	Ind.	Days	ST	Maint	AR
Other immunosuppressive medication, specify: <input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other immunosuppressive medication, specify: <input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>