Pediatric Lung Transplant Candidate 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.

Provider Information				
Recipient Center:				
Candidate Information				
Organ Registered:		Date of	Listing or Add:	
Last Name: *	First Name: *	MI:		
Previous Surname:				
SSN:		Birth se	x:*	○Male ○Female
HIC:		DOB:*		
State of Permanent Residence: *	[
Permanent ZIP Code: *	[-		
Ethnicity: *	r Latino ONot Hispanic	or Latino OEthnicity n	ot reported	
Race: *				
American Indian or Alaska Native	Asia	n		
□American Indian □Eskimo	□ _A	sian Indian/Indian Sub-Co hinese	ontinent	
Aleutian	□F	lipino		
☐Alaska Indian ☐American Indian or Alaska Native: Ot		apanese orean		
American Indian or Alaska Native: Or	rigin not reported V	ietnamese		
		sian: Other origin sian: Origin not reported		
Black or African American		ve Hawaiian or Other Pac	ific Islander	
African American		ative Hawaiian		
□African (Continental) □West Indian		uamanian or Chamorro amoan		
Haitian		ative Hawaiian or Other P	Pacific Islander: Other origin	
☐Black or African American: Other original Black or African American: Origin not		ative Hawaiian or Other P	Pacific Islander: Origin not report	ed
White	Oth	er		
European Descent		ace not reported		
Arab or Middle Eastern North African (non-Black)				
White: Other origin White: Origin not reported				
		O		
Citizenship: *		OUS Citizen		
		Non-US Citizen/US	Resident	
		Other Than Transplan	US Resident, Traveled to US to the state of the US to the state of the US to	for Reason
		Non-US Citizen/Non-I Transplant	US Resident, Traveled to US	for
Country of Permanent Residence	e: [
Year of Entry to the U.S.				ST=
Highest Education Level: *		ONONE		
		GRADE SCHOOL (0-	·8)	
		OHIGH SCHOOL (9-1	2) or GED	
		OATTENDED COLLEG	E/TECHNICAL SCHOOL	
		OASSOCIATE/BACHE		
		POST-COLLEGE GRA		
		ON/A (< 5 YRS OLD)		
		OUNKNOWN		
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	○YES ○NO			
	☐ Extra Corporeal Memi	orane Oxygenation		
	☐ Intra Aortic Balloon P	, -		
	Prostacyclin Infusion			
	Prostacyclin Inhalatio	n		
	☐ Intravenous Inotrope	5		
	☐ Inhaled NO			
	Ventilator	16		
Specify:	Other Mechanism, Sp	ecity		
		1		
Functional Status: *				
Cognitive Development: *	_	Definite Cognitive delay/impairment		
	Probable Cognitive			
	Questionable Cogn	itive delay/impairment		
	No Cognitive delay	/impairment		
	Not Assessed			
Motor Development: *	Openinite Motor dela	Operinite Motor delay/impairment		
	Probable Motor de	Probable Motor delay/impairment		
	Questionable Moto	r delay/impairment		
	No Motor delay/im	pairment		
	Not Assessed			
Academic Progress:*	Within One Grade	evel of Peers		
	Delayed Grade Lev	el		
	Special Education			
	Not Applicable, too	young for school/ High School	graduate or GED	
	Status Unknown			
Academic Activity Level:*	Full academic load			
	Reduced academic	load		
	Unable to participa	te in academics due to disease	or condition	
		te regularly due to dialysis		
	Not Applicable, too	young for school/ High School	graduate or GED	
	Ct-t U-l			
	Status Unknown			
		Graft Fail Date		
	OStatus Unknown Date	Graft Fail Date		
Organ The three most recent transplants are listed here	Date		plants by calling 800-978-4334 or b	
Organ The three most recent transplants are listed here emailing unethelpdesk@unos.org. Source of Payment:	Date		olants by calling 800-978-4334 or b	
Previous Transplants: Organ The three most recent transplants are listed here emailing unethelpdesk@unos.org. Source of Payment: Primary: *	Date		plants by calling 800-978-4334 or b	
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The three most recent transplants are listed here remailing unethelpdesk@unos.org. Source of Payment: Primary: * Specify: Clinical Information: AT LISTING Height Measurement Date:	Date e. Please contact the UNet Help Desk to con		plants by calling 800-978-4334 or b	
Organ The three most recent transplants are listed here emailing unethelpdesk@unos.org. Source of Payment: Primary: * Specify: Clinical Information: AT LISTING Height Measurement Date: Height: *	Date e. Please contact the UNet Help Desk to cond	firm more than three previous trans		
The three most recent transplants are listed here emailing unethelpdesk@unos.org. Source of Payment: Primary: * Specify: Clinical Information: AT LISTING	Date e. Please contact the UNet Help Desk to conditions G	firm more than three previous trans		
The three most recent transplants are listed here emailing unethelpdesk@unos.org. Source of Payment: Primary: * Specify: Clinical Information: AT LISTING Height Measurement Date: Height Measurement Date: Weight Measurement Date:	Date e. Please contact the UNet Help Desk to cond ft	firm more than three previous transp	ST=	
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The three most recent transplants are listed here emailing unethelpdesk@unos.org. Source of Payment: Primary: * Specify: Clinical Information: AT LISTING Height Measurement Date: Height: * Weight Measurement Date: Weight: * BMI: ABO Blood Group:	Date e. Please contact the UNet Help Desk to cond ft	firm more than three previous transp	ST=	
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Type I Type Unknown Type Unkno	Diabetes: *	ONo		
Type Other Type Unknown Diabetes Status Unknown Diabetes Status Unknown Any previous Malignancy:* YES NO Specify Type: Specify Type: Skin Melanoma Skin Non-Melanoma Genitourinary Genesat Trityroid Trityroid Trityroid Trityroid Trityroid Cother, specify Specify: Total Serum Albumin:* Step Medical Factors Pulmonary Status: Pan-Resistant Bacterial Lung Infection:* Wes NO UNK Heart/Lung Medical Factors: Most Recent Hemodynamics: PA (xys) mm/Hg:* ST= YES NO PA (mean) mm/Hg:* ST= YES NO History of Cigarette Use:* YES NO History of Cigarette Use:* YES NO History of Cigarette Use:* YES NO Unk History of Cigarette Use:* YES NO O-2 months 3-12 months 3-3-48 months 3-3-60 months 3-3-60 months 3-60 months 3-6		Туре I		
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Any previous Malignancy:* YES NO		Type Other		
Any previous Malignancy:# Seecify Type: Skin Melanoma Skin Non-Melanoma CNS Tumor Genitourinary Breast Thyroid Trongue/Throat/Larynx Lung Lung Medical Factors Pulmonary Status: Pan-Resistant Sacterial Lung Infection:* Pan-Resistant Sacterial Lung Infection:* Pan-Resistant Sacterial Lung Infection:* Total Rerum Albumin: ST = VES NO PA (ray) mm/Hg:* ST = VES NO PA (mean) mm/Hg:* ST = VES NO History of Cigarette Use:* PURS NO History of Cigarette Use:* PES NO History of Cigarette Use:* PES NO O-2 months 3-12 months 3-12 months 3-3-48 months 49-60 months -60 m		Type Unknown		
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Specify Type: Skin Melanoma				
Skin Non-Melanoma	Any previous Malignancy:*	YES NO		
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Breast Trhyroid		□CNS Tumor		
Breast Trhyroid		Genitourinary		
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Conjunct Continues To Smoke Continues To Smok		☐Thyroid		
Lung Leukemia/Lymphoma Liver Other, specify Specify; Total Serum Albumin: *				
Leukemia/Lymphoma				
Cother, specify Specify: Total Serum Albumin: # 9/dl ST = Lung Medical Factors Pulmonary Status: Pan-Resistant Bacterial Lung Infection: * YES NO UNK Heart/Lung Medical Factors: Most Recent Hemodynamics: PA (sys) mm/Hg: * ST = YES NO PA (dia) mm/Hg: * ST = YES NO PA (mean) mm/Hg: * ST = YES NO PCW (mean) mm/Hg: * ST = YES NO Duration of Abstinence: O-2 months 33-12 months 13-24 months 25-36 months 37-48 months 49-60 months Oon tinues To Smoke Unknown duration		_		
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PA (mean) mm/Hg:* ST= YES NO PCW (mean) mm/Hg:* ST= YES NO CO L/min:* YES NO Duration of Abstinence: 0-2 months 3-12 months 13-24 months 25-36 months 37-48 months 49-60 months Continues To Smoke Unknown duration			ST=	
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49-60 months >60 months Continues To Smoke Unknown duration				
>60 months Continues To Smoke Unknown duration				
Continues To Smoke Unknown duration				
OUnknown duration				
Prior Thoracic Surgery other than prior transplant:* YES NO UNK				
	Prior Thoracic Surgery other than prior transplant: $\!$	OYES ONO OUNK		
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If yes, number of prior sternotomies:	Ounknown if there were prior sternotomies		
	○ o		
	O ₁		
	○2		
	○3		
	04		
	○5+		
	Ounknown number of prior sternotomies		
If yes, number of prior thoracotomies:	Ounknown if there were prior thoracotomies		
	○ o		
	\bigcirc_{1}		
	0 2		
	○3		
	04		
	○5+		
	Ounknown number of prior thoracotomies		
Prior congenital cardiac surgery:	YES NO UNK		
If yes, palliative surgery:	OYES ONO OUNK		
If yes, corrective surgery:	OYES ONO OUNK		
If yes, single ventricular physiology:	YES NO UNK		

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