

Records ?

Adult Lung Transplant Candidate Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 07/31/2020

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:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Previous Surname:		
<input type="text"/>		
SSN:	Gender:*	<input type="radio"/> Male <input type="radio"/> Female
<input type="text"/>	<input type="text"/>	<input type="text"/>
HIC:	DOB:*	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
State of Permanent Residence:*	<input type="text"/>	
Permanent ZIP Code:*	<input type="text"/> - <input type="text"/>	
Ethnicity/Race:* (select all origins that apply)		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Eskimo <input type="checkbox"/> Aleutian <input type="checkbox"/> Alaska Indian <input type="checkbox"/> American Indian or Alaska Native: Other <input type="checkbox"/> American Indian or Alaska Native: Not Specified/Unknown	<input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian/Indian Sub-Continent <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian: Other <input type="checkbox"/> Asian: Not Specified/Unknown	<input type="checkbox"/> Black or African American <input type="checkbox"/> African American <input type="checkbox"/> African (Continental) <input type="checkbox"/> West Indian <input type="checkbox"/> Haitian <input type="checkbox"/> Black or African American: Other <input type="checkbox"/> Black or African American: Not Specified/Unknown
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Native Hawaiian or Other Pacific Islander: Other <input type="checkbox"/> Native Hawaiian or Other Pacific Islander: Not Specified/Unknown	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican (Mainland) <input type="checkbox"/> Puerto Rican (Island) <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic/Latino: Other <input type="checkbox"/> Hispanic/Latino: Not Specified/Unknown	<input type="checkbox"/> White <input type="checkbox"/> European Descent <input type="checkbox"/> Arab or Middle Eastern <input type="checkbox"/> North African (non-Black) <input type="checkbox"/> White: Other <input type="checkbox"/> White: Not Specified/Unknown
Citizenship:*	<input type="radio"/> US Citizen <input type="radio"/> Non-US Citizen/US Resident <input type="radio"/> Non-US Citizen/Non-US Resident, Traveled to US for Reason Other Than Transplant <input type="radio"/> Non-US Citizen/Non-US Resident, Traveled to US for Transplant	
Country of Permanent Residence:	<input type="text"/>	
Year of Entry to the U.S.	<input type="text"/>	ST= <input type="checkbox"/>
Highest Education Level:*	<input type="radio"/> NONE <input type="radio"/> GRADE SCHOOL (0-8) <input type="radio"/> HIGH SCHOOL (9-12) or GED <input type="radio"/> ATTENDED COLLEGE/TECHNICAL SCHOOL <input type="radio"/> ASSOCIATE/BACHELOR DEGREE <input type="radio"/> POST-COLLEGE GRADUATE DEGREE <input type="radio"/> N/A (< 5 YRS OLD) <input type="radio"/> UNKNOWN	
Patient on Life Support:*	<input type="radio"/> YES <input type="radio"/> NO	

- Extra Corporeal Membrane Oxygenation
- Intra Aortic Balloon Pump
- Prostacyclin Infusion
- Prostacyclin Inhalation
- Inhaled NO
- Ventilator
- Other Mechanism, Specify

Specify:

Functional Status:*

Working for income:*

YES NO UNK

Previous Transplants:

Organ	Date	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.

Source of Payment:

Primary:*

Specify:

Clinical Information: AT LISTING

Height:*

ft. in.

cm

ST=

Weight:*

lbs

kg

ST=

BMI:

kg/m²

ABO Blood Group:

Primary Diagnosis:*

Specify:

General Medical Factors:

- No
- Type I
- Type II
- Type Other
- Type Unknown
- Diabetes Status Unknown

Diabetes:*

Any previous Malignancy:*

YES NO

- Skin Melanoma
- Skin Non-Melanoma
- CNS Tumor
- Genitourinary
- Breast
- Thyroid
- Tongue/Throat/Larynx
- Lung
- Leukemia/Lymphoma
- Liver
- Other, specify

Specify Type:

Specify:

Lung Medical Factors

Pulmonary Status:

Pan-Resistant Bacterial Lung Infection:*

YES NO UNK

Heart/Lung Medical Factors:

Most Recent Hemodynamics:

Inotropes/Vasodilators:

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

CO L/min:*

ST=

YES NO

History of Cigarette Use:*

YES NO

0-2 months

3-12 months

13-24 months

25-36 months

Duration of Abstinence:

37-48 months

49-60 months

>60 months

Continues To Smoke

Unknown duration

Prior Cardiac Surgery (non-transplant): *

YES NO UNK

CABG

Valve Replacement/Repair

If yes, check all that apply:

Congenital

Left Ventricular Remodeling

Other, specify

Specify: