

Records ?

Adult Intestine Transplant Recipient 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.

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

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

Donor Information	
UNOS Donor ID #:	
Recovering OPO:	
Donor Type:	

Patient Status	
Primary Diagnosis:*	<input type="text"/>
Specify:	<input type="text"/>
Secondary 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 <input type="checkbox"/> Ventilator <input type="checkbox"/> Artificial Liver <input type="checkbox"/> Other Mechanism, Specify Specify: <input type="text"/>
Functional Status:*	<input type="text"/>
Working for income:*	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Source of Payment:	
Primary:*	<input type="text"/>
Specify:	<input type="text"/>
Height:*	<input type="text"/> ft. <input type="text"/> in. <input type="text"/> cm ST= <input type="text"/>

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

NAT Results:

HIV NAT: *

Positive
 Negative
 Not Done
 UNK/ Cannot Disclose

HBV NAT: *

Positive
 Negative
 Not Done
 UNK/ Cannot Disclose

HCV NAT: *

Positive
 Negative
 Not Done
 UNK/ Cannot Disclose

Total Bilirubin: * mg/dl ST=

Serum Albumin: * g/dl ST=

Serum Creatinine: * mg/dl ST=

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Information:

Intestine Venous Drainage: * Portal Systemic

Native Viscera Venous Drainage: * Portal Systemic

Procedure Type: Whole Intestine
 Intestine Segment
 Whole Intestine with Pancreas (Technical Reasons)
 Intestine Segment with Pancreas (Technical Reasons)

Organ Type: * Stomach
 Small Intestine
 Duodenum
 Large Intestine

Preservation Information:

Total Ischemic Time (include cold, warm and anastomotic time): * hrs ST=

Risk Factors:

Recent Septicemia: * YES NO UNK

Exhausted Vascular Access: * YES NO UNK

Previous Abdominal Surgery: * YES NO UNK

Dilated/Non-Functional Bowel Segments: * YES NO UNK

Other:

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.

TPN Dependent: YES NO

IV Dependent: YES NO

Oral Feeding: YES NO

Tube Feed: YES NO

Date of Graft Failure:

Primary Cause of Graft Failure: RECURRENT TUMOR
 ACUTE REJECTION
 CHRONIC REJECTION
 TECHNICAL PROBLEMS
 INFECTION
 LYMPHOPROLIFERATIVE DISEASE
 GRAFT VERSUS HOST DISEASE
 ISCHEMIA/NEC LIKE SYNDROME
 OTHER SPECIFY

Specify:

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