Records

Pediatric Kidney-Pancreas Transplant Recipient Follow-Up 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:**

Previous Follow-Up: **Previous Px Stat Date:**

Transplant Discharge Date:

State of Permanent Residence: *

Zip Code: * -

Provider Information

Recipient Center:

Followup Center:

Physician Name: *

NPI#: *

Follow-up Care Provided By: *

- Transplant Center
- Non Transplant Center Specialty Physician
- Primary Care Physician
- Other Specify

Specify:

Donor Information

UNOS Donor ID #:

Recovering OPO:

Donor Type:

Patient Status

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED
- NOT SEEN

If Retransplanted, choose organ(s): Kidney Pancreas Kidney/Pancreas

Primary Cause of Death:

Specify:

Contributory Cause of Death:

Specify:

Contributory Cause of Death:

Specify:

Has the patient been hospitalized since the last patient status date: * YES NO UNK

Functional Status: *

Cognitive Development: *

- Definite Cognitive delay/impairment
- Probable Cognitive delay/impairment
- Questionable Cognitive delay/impairment
- No Cognitive delay/impairment
- Not Assessed

Motor Development: *

- Definite Motor delay/impairment
- Probable Motor delay/impairment
- Questionable Motor delay/impairment

- ○ No Motor delay/impairment
- ○ Not Assessed

Academic Progress: *

- ○ Within One Grade Level of Peers
- ○ Delayed Grade Level
- ○ Special Education
- ○ Not Applicable < 5 years old/ High School graduate or GED
- ○ Status Unknown

Academic Activity Level: *

- ○ Full academic load
- ○ Reduced academic load
- ○ Unable to participate in academics due to disease or condition
- ○ Not Applicable < 5 years old/ High School graduate or GED
- ○ Status Unknown

Primary Insurance at Follow-up: *

Specify:

Clinical Information

Date of Measurement:

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

Weight: * lbs. kg **ST=**

BMI: kg/m^2

Kidney 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.

Kidney Date of Failure:

Kidney Primary Cause of Graft Failure:

Specify

If Functioning, Most Recent Serum Creatinine: mg/dl **ST=**

Dialysis Since Last Follow-Up:

- ○ NO
- ○ Yes, returned to chronic maintenance dialysis (ESRD)
- ○ Yes, returned to (or continued on) temporary dialysis

Date Maintenance Dialysis Resumed:

Pancreas Graft Status: * ○ Functioning ○ Failed

If death is indicated for the recipient, report graft status up until the instance of death.

Patient using any method of blood sugar control: ○ YES ○ NO ○ UNK

Patient on oral medication to control blood sugar? * ○ YES ○ NO ○ UNK

Date of medications resumed: * ST=

Patient using diet to control blood sugar: * ○ YES ○ NO ○ UNK

Patient on insulin? ○ YES ○ NO ○ UNK

Date insulin resumed: * ST=

Total insulin dosage units: * ST=

Insulin duration of use: * days ST=

C-peptide value: ng/mL **ST=**

HbA1c: % **ST=**

Pancreas Date of Failure

Pancreas Primary Causes of Graft Failure

Specify:

Pancreas Graft/Vascular Thrombosis ○ YES ○ NO ○ UNK

Pancreas Infection ○ YES ○ NO ○ UNK

Pancreas Bleeding ○ YES ○ NO ○ UNK

Anastomotic Leak ○ YES ○ NO ○ UNK

Pancreas Rejection: Acute ○ YES ○ NO ○ UNK

Pancreas Chronic Rejection ○ YES ○ NO ○ UNK

Biopsy Proven Isletitis ○ YES ○ NO ○ UNK

Pancreatitis ○ YES ○ NO ○ UNK

Patient Noncompliance ○ YES ○ NO ○ UNK

Other, Specify:

Conv. From Bladder to Enteric Drain Performed: ○ YES ○ NO ○ UNK

Enteric Drain Date:

Pancreas Transplant Complications (Not leading to graft failure):

Pancreatitis ○ YES ○ NO ○ UNK

Anastomotic Leak ○ YES ○ NO ○ UNK

Abscess or Local Infection: ○ YES ○ NO ○ UNK

Other, Specify:

Did patient have any kidney acute rejection episodes during the follow-up period:

○ **Yes, at least one episode treated with anti-rejection agent**
○ **Yes, none treated with additional anti-rejection agent**
○ **No**
○ **Unknown**

Did patient have any pancreas acute rejection episodes during the follow-up period:

○ **Yes, at least one episode treated with anti-rejection agent**
○ **Yes, none treated with additional anti-rejection agent**
○ **No**
○ **Unknown**

Is growth hormone therapy used during this followup period: * ○ YES ○ NO ○ UNK

Viral Detection:

CMV IgG: *

○ **Positive**
○ **Negative**
○ **Not Done**
○ **UNK/Cannot Disclose**

CMV IgM: *

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

HIV Serology

- Positive
- Negative
- UKN/Cannot Disclose
- Not Done

HIV NAT

- Positive
- Negative
- UKN/Cannot Disclose
- Not Done

HbsAg

- Positive
- Negative
- UKN/Cannot Disclose
- Not Done

HBV DNA

- Positive
- Negative
- UKN/Cannot Disclose
- Not Done

HBV Core Antibody

- Positive
- Negative
- UKN/Cannot Disclose
- Not Done

HCV Serology

- Positive
- Negative
- UKN/Cannot Disclose
- Not Done

HCV NAT

- Positive
- Negative
- UKN/Cannot Disclose
- Not Done

Post Transplant Malignancy: * ○ YES ○ NO ○ UNK

Donor Related: ○ YES ○ NO ○ UNK

Recurrence of Pre-Tx Tumor: ○ YES ○ NO ○ UNK

De Novo Solid Tumor: ○ YES ○ NO ○ UNK

De Novo Lymphoproliferative disease and Lymphoma: ○ YES ○ NO ○ UNK

Bone Disease:

Fracture in the past year (or since last follow-up): * ○ YES ○ NO ○ UNK

Specify Location and number of fractures: *

- ☐ Spine-compression fracture: # of fractures: ____
- ☐ Extremity: # of fractures: ____
- ☐ Other: # of fractures: ____

AVN (avascular necrosis): * ○ YES ○ NO ○ UNK

Immunosuppressive Information

Previous Validated Maintenance Follow-Up Medications:

Previous Validated Maintenance Follow-Up Medications:

Were any medications given during the follow-up period for maintenance:

- Yes, same as validated TRR form
- None given

○ **Yes, but different than validated TRR form**

Immunosuppressive Medications

View Immunosuppressive Medications

Definitions Of Immunosuppressive Follow-Up Medications

For each of the immunosuppressant medications listed, check **Previous Maintenance (Prev Maint)**, **Current Maintenance (Curr Maint)** or **Anti-rejection (AR)** to indicate all medications that were prescribed for the recipient during this follow-up period, and for what reason. If a medication was not given, leave the associated box(es) blank.

Previous Maintenance (Prev Maint) includes all immunosuppressive medications given during the report period, which covers the period from the last clinic visit to the current clinic visit, *for varying periods of time which may be either long-term or intermediate term with a tapering of the dosage until the drug is either eliminated or replaced by another long-term maintenance drug* (example: Prednisone, Cyclosporine, Tacrolimus, Mycophenolate Mofetil, Azathioprine, or Rapamycin). This does not include any immunosuppressive medications given to treat rejection episodes.

Current Maintenance (Curr Maint) includes all immunosuppressive medications given at the current clinic visit to begin in the next report *for varying periods of time which may be either long-term or intermediate term with a tapering of the dosage until the drug is either eliminated or replaced by another long-term maintenance drug* (example: Prednisone, Cyclosporine, Tacrolimus, Mycophenolate Mofetil, Azathioprine, or Rapamycin). This does not include any immunosuppressive medications given to treat rejection episodes.

Anti-rejection (AR) immunosuppression includes all immunosuppressive medications given for the purpose of treating an acute rejection episode since the last clinic visit (example: Methylprednisolone, Atgam, OKT3, 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.
Note: The Anti-rejection field refers to any anti-rejection medications since the last clinic visit, not just at the time of the current clinic visit.

If an immunosuppressive medication other than those listed is being administered (e.g., new monoclonal antibodies), select Previous Maint, or Current 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

	Prev Maint	Curr Maint	AR
Steroids (prednisone, methylprednisolone, Solumedrol, Medrol, Decadron)	☐	☐	☐

Drugs used for induction or acute rejection

	Prev Maint	Curr Maint	AR
Atgam	☐	☐	☐
Campath (alemtuzumab, anti-CD52)	☐	☐	☐
Cytoxan (cyclophosphamide)	☐	☐	☐
Methotrexate (Folex PFS, Mexate-AQ, Rheumatrex)	☐	☐	☐
OKT3 (Orthoclone, muromonab)	☐	☐	☐
Rituxan (rituximab)	☐	☐	☐
Simulect (basiliximab)	☐	☐	☐
Thymoglobulin	☐	☐	☐

Drugs primarily used for maintenance

	Prev Maint	Curr Maint	AR
Cyclosporine, select from the following:			
- EON (generic cyclosporine)	☐	☐	☐
- Gengraf (Abbott cyclosporine)	☐	☐	☐
- Neoral (CyA-NOF)	☐	☐	☐
- Other generic cyclosporine, specify brand:	☐	☐	☐
- Sandimmune (cyclosporine A)	☐	☐	☐
Imuran (azathioprine, AZA)	☐	☐	☐
Leflunomide (LFL)	☐	☐	☐
Mycophenolate acid, select from the following:			
- CellCept (MMF)	☐	☐	☐
- Generic MMF (generic CellCept)	☐	☐	☐
- Myfortic (mycophenolate acid)	☐	☐	☐
Nulojix (belatacept)	☐	☐	☐
Rapamune (sirolimus, Rapamycin)	☐	☐	☐
Tacrolimus, select from the following:			
- Astagraf XL (extended release tacrolimus)	☐	☐	☐
- Generic tacrolimus (generic Prograf)	☐	☐	☐
- Prograf (FK506)	☐	☐	☐
Zortress (everolimus)	☐	☐	☐

Other drugs

	Prev Maint	Curr Maint	AR
Other immunosuppressive medication, specify:	☐	☐	☐
Other immunosuppressive medication, specify:	☐	☐	☐