

# Records ?

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

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

Donor Information	
<b>UNOS Donor ID #:</b>	
<b>Recovering OPO:</b>	
<b>Donor Type:</b>	

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

Clinical Information : PRETRANSPLANT	
<b>Medical Condition at time of transplant:*</b>	<input type="radio"/> IN INTENSIVE CARE UNIT <input type="radio"/> HOSPITALIZED NOT IN ICU <input type="radio"/> NOT HOSPITALIZED
<b>Patient on Life Support:*</b>	<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"/>
<b>Functional Status:*</b>	<input type="text"/>
<b>Cognitive Development:*</b>	<input type="radio"/> Definite Cognitive delay/impairment <input type="radio"/> Probable Cognitive delay/impairment <input type="radio"/> Questionable Cognitive delay/impairment <input type="radio"/> No Cognitive delay/impairment <input type="radio"/> Not Assessed
<b>Motor Development:*</b>	<input type="radio"/> 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

Source of Payment:

Primary:\*

Specify:

Date of Measurement:

Height:\*

 ft.  in.

 cm

ST=

Weight:\*

 lbs

 kg

ST=

BMI:

 kg/m<sup>2</sup>

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

Has the recipient ever had a diagnosis of HCC? \*  YES  NO

**Clinical Information : TRANSPLANT PROCEDURE**

**Multiple Organ Recipient**

Were extra vessels used in the transplant procedure:

**Procedure Type:**

- Whole Liver
- Partial Liver, remainder not Tx or Living Transplant
- Split Liver
- Whole Liver with Pancreas (Technical Reasons)
- Partial Liver with Pancreas (Technical Reasons)
- Split Liver with Pancreas (Technical Reasons)

**Split Type:**

Preservation Information:

Total Cold Ischemia Time (if pumped, include pump time): \*  hrs ST=

Risk Factors:

Previous Abdominal Surgery: \*  YES  NO  UNK

Portal Vein Thrombosis: \*  YES  NO  UNK

Transjugular Intrahepatic Portosystemic Shunt: \*  YES  NO  UNK

**Clinical Information : POST TRANSPLANT**

Pathology Conf. Liver Diag. of Hospital Discharge: \*

Specify:

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.

Date of Graft Failure:

Causes of graft failure:

Primary Non Function  YES  NO  UNK

Hepatic Artery Thrombosis  YES  NO  UNK

Other Vascular Thrombosis  YES  NO  UNK

Portal Vein Thrombosis:  YES  NO  UNK

Hepatic Outflow Obstruction:  YES  NO  UNK

Diffuse Cholangiopathy

YES  NO  UNK

Hepatitis: DeNovo

YES  NO  UNK

Hepatitis: Recurrent

YES  NO  UNK

Recurrent Disease (non-Hepatitis)

YES  NO  UNK

Acute Rejection

YES  NO  UNK

Infection

YES  NO  UNK

Other, 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**