Transplant Candidate Registration Form (Please print or type all information) FORM APPROVED: O.M.

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Submitting this paper form does not add your patient to the waiting list.

Page 1 of 2

Provider	Provider Information Organ Registered: Kidney						
Provider Number	UNOS Center Code Center Nar	ne	Date placed	on list:			
	e Information						
			Provious Surnama:				
Name:			_ Previous Surname:				
			HIC: Gend			emale	
State of Perm	nanent Residence:	Permanent Zip Cod	e: Waiting Zip Cod	de:			
Ethnicity	O Hispanic/Latino	O Non-Hispanic/Non-Latino	Employment Status (Select one) (Work Working Full Time	ing = Employ	ed, Home	, School)	
Americo Nativo Asian Citizenship (Select one)	Indian or Alaskan Mid-East or Arabian Indian Sub-Continent Not Working By Choice Not Working Due to Disease Not Working, Unable to Find Employment Not Working, Reason Unknown Retired					
_	esident Alien country:		O Patient Less Than Five Years O	ld			
			Previous Transplants				
○ None○ Grade○ High S	School (0-8) school (9-12) ed College/Technical	Associate/BachelorDegreePost-College GraduateDegreeUnknown	Yes No If Yes, give the number of previous transplated latest transplant date. Number Kidney Liver Pancreas (whole)	Date	organ type	e and	
Medical Condition (Select one) Patient in Intensive Care Unit Hospitalized, but not in Intensive Care Unit Not hospitalized Patient on Life Support			Pancreas (islet cells) Heart Lung Intestine Bone Marrow				
	e for all patients regardless of	f medical status)	Source of Payment				
		☐ IABP	(Check Yes, No or Unknown for each secor Primary (Largest %, Select one)		of paymer econdary		
☐ PGE ☐ Ventila		☐ IV Inotropes ☐ Other mechanism Specify:	MedicareMedicaidUS/State Government Agency	○ Y ○ Y ○ Y	○ N ○ N ○ N	Ο U Ο U	
VAD Brand Cardio Abiome Novace Heartm	West ed or	○ Thoratec○ Other VAD, specify:	Private InsuranceHMO/PPOSelfDonationFree Care	O Y O Y O Y O Y	O N O N O N O N		
Functional Status (Select one) (How does patient perform daily activities?) No activity limitations. (NYHA Class I or Class II) Performs activities of daily living with some assistance. (NYHA Class III) Performs activities of daily living with total assistance. (NYHA Class IV) N/A Patient hospitalized Unknown			○ Dept. of Veterans Affairs○ Pending○ Foreign Govt., Specify:				

Transplant Candidate Registration Form

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Page 2 of 2 Clinical Information Height _____ ft. ____ in. OR _____ cm Weight _____ lbs. OR _____ kg ABO Blood Group: Rh: Primary Diagnosis (Use codes) _____ If other, specify: _____ **General Medical Factors Diabetes** O No Diabetes Insulin Dependent Diabetes O Non-Insulin Dependent Diabetes O Diabetes, Dependency Unknown O Unknown **Dialysis** O No Dialysis Hemodialysis O Peritoneal Dialysis **Peptic Ulcer Disease** O No O Yes, Drug Treated O Yes, Not Drug Treated O Yes, Drug Treatment Unknown O Unknown Angina/Coronary Artery Disease O No Angina, Unstable O Angina, Stable O Angina, Stability Unknown O Unknown Drug Treated Systemic Hypertension OY ON OU OYONOU Symptomatic Cerebrovascular Disease Symptomatic Peripheral Vascular Disease OYONOU \bigcirc Y \bigcirc N \bigcirc U Drug Treated COPD Pulmonary Embolism (within last 6 months) O Y O N O U OY ON OU Any Previous Transfusions Any Previous Malignancy OY ON OU (Exclude non-melanoma skin cancer) PRA > 10% (with DTT or DTE testing) \bigcirc Y \bigcirc N \bigcirc U Most recent absolute Creatinine _____ mg/dl _____ g/dl Total Serum Albumin **Kidney Medical Factors** Exhausted vascular access OYONOU OY ON OU Exhausted peritoneal access Age of diabetes onset _____ yrs Creatinine clearance _____ ml/min Creatinine clearance method: O Calculated O Measured Standard Stope

UNOS/PHS/HCFA 1/28/00

Person completing form:

Kidney Transplant Recipient Registration Form (Please print or type all information) FORM APPROVED: O.M.B. NO. 09

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Provider Information		
Provider Number Center Code Transplant Center Name	Surgeon Name	UPIN Number
Recipient Information	Ü	
Name:	Transplant Date:	
DOB: SSN:	_	
Patient Status	Donor Information Donor Type	:
	Bonor mornation	•
Primary Diagnosis Specify:	UNOS Donor ID Donor Name: Last	First
Patient Status	Source of Payment (Check Yes, No or Unk for each	secondary source)
Date: of Report or Death		Secondary
O Living	Medicare O Y	
Dead Cause of Death:(Use code)	○ Medicaid ○ Y	\bigcirc N \bigcirc U
Specify:	○ US/State Government Agency ○ Y	\bigcirc N \bigcirc U
Retransplanted prior to hospital discharge	O Private Insurance O Y	\bigcirc N \bigcirc U
	O HMO/PPO O Y	\bigcirc N \bigcirc U
Transplant Hospitalization	Self Y Donation Y	ON OU
Date of discharge from transplant center:	Free Care Y	\bigcirc N \bigcirc U \bigcirc N \bigcirc U
Date of admission to transplant center:	Dept. of Veterans Affairs	\bigcirc N \bigcirc U
Was patient transferred from another hospital prior to transplant?	Foreign Gov't. Specify:	
○ Yes ○ No	g ready.	
If Yes, date of admission to transferring hospital:		
Medical Condition at Time of Transplant (Select one)	Pretransplant Clinical Information	
O Patient in Intensive Care Unit	Previous Kidney Transplants	s 🔾 No
O Hospitalized, but not in Intensive Care Unit	If Yes, number of previous kidney transplants:	
O Not hospitalized	Previous Tx Transplant Date Grant	aft Failure Date
Patient on Life Support Yes No (Please provide for all patients regardless of medical status)	Most recent	
(Please provide for all patients regardless of medical status)	2nd most recent	
Functional Status (How does the patient perform activities	3rd most recent	
of daily living? Select one)	Pretransplant Dialysis	
No activity limitations. (NYHA Class I or Class II)	■	ritoneal dialysis
 Performs activities of daily living with some assistance. (NYHA Class III) 	If Yes, date first dialyzed:	
Performs activities of daily living with total assistance.	Average daily insulin: uni Serum Creatinine at time of transplant: mg	
(NYHA Class IV)		min
O N/A Patient hospitalized	Creatinine clearance method:	
Ounknown	○ Isotope ○ Calculated ○ Me	asured standard
Employment Status (Select one) (Working = Employed, Home, School)	Pretransplant Serology	
Working Full Time	HIV Screening P N	U ND I C
Working Part Time By Choice	Confirmation P N	U ND I C
Working Part Time Due to Disease	CMV IgG P N	U ND I C
Working Part Time, Reason Unknown	IgM P N DNA P N	U ND I C
Not Working By Choice	Hepatitis B Core Antibody P N	U ND I C
Not Working Due to Disease	Surface Antigen P N	U ND I C
	HBV DNA P N	U ND I C
Not Working, Unable to Find Employment	Hepatitis C Antibody Screen P N	U ND I C
O Not Working, Reason Unknown	RIBA Test P N HCV RNA P N	U ND I C
Retired	Epstein Barr Virus IgG P N	U ND I C
Employment Status Unknown	IgM P N	U ND I C
O Patient Less Than Five Years Old	DNA P N	U ND I C

Kidney Transplant Recipient Registration Form FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Name:		Page	2 of 2
Biopsy of Donor Kidney at Transplant Center	Most recent Serum Creatinine prior to discharge:		_ mg/dl
O No biopsy done	Did kidney produce > 40 ml of urine in the	() Y	() N
Frozen Left Kidney Permanent Left Kidney	first 24 hours?	O 1	O 14
Frozen Right Kidney	Did patient need dialysis within first week?	○ Y	\bigcirc N
Permanent Right Kidney	Did Creatinine decline by 25% or more in first	O Y	\bigcirc N
Frozen En-bloc Kidney	24 hours on 2 separate serum samples taken	0 '	O 14
Permanent En-bloc Kidney	within the first 24 hours?		
	Within the first 24 flours:		
Kidney Results:	Rejection Information		
Glomerulosclerosis % Fibrosis Arteriolosclerosis	Patient treated for rejection?	\bigcirc Y	\bigcirc N
○ 0-5○ None○ 6-10○ Mild○ Mild	If Yes, biopsy done?	\bigcirc Y	\bigcirc N
11-15	If Yes, rejection confirmed?	○ Y	\bigcirc N
16-20 Clarge Clarge	BANFF Level:	\bigcirc Y	\bigcirc N
>20	Stages: 0 1A 1B 2	○ 3	
Pretransplant Blood Transfusions:	Height ft in. OR		
0 0-1-5 6-10 >10 Unk	Weight lbs. OR	K	g
Date of last transfusion:	Treatment		
	Immunosuppressive Information		
Number of previous pregnancies:	Are any medications given currently for	() Y	\bigcirc N
0 01 02 03 04 05 0>5 Unk	maintenance or anti-rejection:	0.	
Any known malignancies since listing: O Yes O No O Unk	Did the patient participate in any clinical	ΟY	ΟN
Transplant Clinical Information	research protocol for immunosuppressive medic	_	
Transplant Clinical Information	If Yes, specify:		
Multiple Organ Recipient:			
Procedure Type:	Other Therapy	O V	\bigcirc N
	Photopheresis Plasmapheresis	○ Y	\bigcirc N
Preservation Information	Total Lymphoid Irradiation (TLI)	\bigcirc Y	\bigcirc N
Total Cold Ischemic Time: hrs	rotal Lymphola madiation (12)	<u></u> .	<i>)</i>
Anastomotic Time: min Warm Ischemic Time: min	Biologicals/Vaccines		
Total Pump Time: hrs min	Cytogam (CMV)	○ Y	\bigcirc N
	Gamimune N 10%	\bigcirc Y	\bigcirc N
Number of blood transfusions at time of transplant:	Gammagard SD	○ Y	\bigcirc N
Post Transplant Clinical Information	Acyclovir (Zovirax)	\bigcirc Y	\bigcirc N
Graft Status: Functioning Failed	Ganciclovir (Cytovene)	○ Y	\bigcirc N
Resumed maintenance dialysis:	HBIG (Hepatitis B Immume Globulin)	\bigcirc Y	\bigcirc N
If Yes, date resumed:	Flu Vaccine (Influenza virus)	○ Y	\bigcirc N
Dialysis center provider #:	Other:		
Dialysis center name:	Other:		
If failed, date of graft failure: Cause of graft failure (Check Yes, No or Unknown for each contributory			
cause of graft failure)			
Primary (Check one) Contributory			
Hyperacute rejection			
○ Graft thrombosis ○ Y ○ N ○ U			
○ Infection ○ Y ○ N ○ U			
Surgical complications			
○ Urological complications ○ Y ○ N ○ U			
Recurrent disease Other: Other:			
Other: Other:			

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Person completing form:

Immunosuppression Treatment (Please print or type all information) FORM APPR

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Recipien	nt Informatio	on					r ago i oi i
-							
Name:		First		MI			
Provider Number	Center Code	Tx Center Name					
Donor In	formation						
DONO! II	ii o i i i i a i i a i i a i i a i i a i a						
UNOS Donor ID	Donor Name: Last	First		_			
Immunosu	opression Thera	іру	المارية والمارية	Dave	Maint	Λ m4: mm:	
STEROID	os		Induct	Days	Maint	Anti-rej	
	sone (Deltasone,	Orasone)					
	·	lu-medrol, Medrol, A-Methapred)					
T-CELL A	ACTIVATION INH	IIBITORS					
		andimmune, CyA, CyS)					
	(CyA-NOF)						
	(Prograf, Tacroli	mus)					
		15-DSG, Gusperimus, Spanidin)					
		olimus, Rapamune)					
	af (Abbot CyA)	· ,					
•	n (RAD, Enverol	imus)					
	ABOLITES	·					
	oprine (AZA, Imu	ran)					
	•	(MMF, Cellcept, RS61443)					
	ın (Cyclophospha	•					
-		S, Mexate-AQ, Rheumatrex)					
	nar Sodium (BRO	-					
	omide (LFL)	~)				H	
	oine (Bredinin)						
		CEPTOR ANTIBODIES					
	(Medimmune)	CELLOK ANTIBODIES					
	•	ocyte Globulin)/NRATG/NRATS					
	(Orthoclone, Mur						
	globulin	omonab)					
Zenapa							
Simule							
	86 - IL - 2						
	CAM - 1						
	IE INHIBITORS		_				
	Receptor Antagor	niet					
Anti - I	•	list					
Allu - II	L - 0						
		ESSIVE MEDICATION					
Other:							
Other:							

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Person completing form: _

Cadaver Donor Registration Form (Please print or type all information) FORM APPROVE

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Provider Information					
OPO Provider Number Center Code OPO Ce	enter Name	Donor Hospital Provider Number	Donor Hospital N	lame	
Date of Referral call:	Recovered outside U.S	: OY ON If Ye	es, country: _		
Donor Information			UN	IOS Donor ID:	
Name:	First	_ DOB:	If U	Jnknown, give	age:
Gender: Male Female	Home City:	State:	н	ome Zip Code	:
Ethnicity O Hispanic/Latino	O Non-Hispanic/Non-Latino	Was Death reported to N	/ledical Exar	niner/Coroner:	
Race	Native Hawaiian or other Pacific Islander Mid-East or Arabian Indian Sub-Continent	Medical examiner Medical examiner Unknown Was the donor's wish to known to the family pr Was a formal organ donary	refused condonate organior to donate	ins OY on request:	
Citizenship (Select one) U.S. Citizen Non-Resident Alien, specify cou		No Yes, family initiate Approached by ph Approached by nu Approached by cle Approached by O	ed nysican urse ergy	, i	,
Cause of Death (Select one) Anoxia/Cardiac Arrest Cerebrovascular/Stroke Other, specify:	O Head Trauma O CNS Tumor	Approached by SoOther, Specify:Written consent for organNo consent obtain	ocial Worker n donation o	btained by: (Se	elect one)
Mechanism of Death (Select one) Drowning Seizure Drug Intoxication Asphyxiation Cardiovascular Electrical Gunshot Wound None of the Above	 Stab Blunt Injury Sudden Infant Death Intracranial Hemorrhage /Stroke Death from Natural Causes 	 ○ OPO Coordinator ○ Social Worker ○ Other, specify: ─ Was the consent based: ○ written documentation If Yes, indicate mecha ○ Driver's license ○ Donor card ○ Donor registry Other, specify: 	solely on of the patie	_iving will Attorney in fact	
Circumstances of Death (Select one)	O Death from Natural Causes O None of the Above	Consent Information Tissue Requested If no, reason code: Other, Specify:		O Y	O N
Procurement and Consent Was donor suitable for procurement If No, select one primary reason: HIV + HCV + Hepatitis B + Tuberculosis Brain death criteria not met Other, specify:	of organs: O Y O N O Medical History O Social History O Cancer O Age	Tissue Consented If no, reason code: Other, Specify: Clinical Informati ABO Blood Group: Height ft Weight lbs.	ON Rh: in.	OR	cm
UNOS/PHS/HCFA 1/28/00					

Date completed: ___

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	lame:				Page	2 of 4
Terminal Lab Data (U=Unknown, ND=Not D	one)	Clinical Infection:		ΟY	ΟN	ΟU
Serum Creatinine mg/dl	,	Source		Confire	ned by	Culture
BUN mg/dl		□ Blood		ΟY		
Total Bilirubin mg/dl		Lung		ŌΥ	ŌΝ	
SGOT/AST u/ml		☐ Urine		ΟY	\bigcirc N	
SGPT/ALT u/ml		Other, specify:		ŎΥ	_	
Protein in urine	OY ON OU			_	_	
Last Serum sodium prior to procurement	OY ON OU					
> 170 mEq/l:	o. o. o.	Heart Donor's Ca	ardiac Functi	on		
Pancreas: (PA donors only)		History of previous MI		\bigcirc Y	\bigcirc N	
Serum Lipase u/L		LV ejection fraction:		_	_	
Serum Amylase u/L		Method:				
a/E		○ Echo				
Medications given to donor (24 hours price	r to cross clamp)	O MUGA				
Anticonvulsants	^ ^ ^	O Angiogram				
Antihypertensives	O Y O N OU	If LV ejection fraction	< 50%:			
Vasodilators	O Y O N OU	Segmental abnorm		ΟY	\bigcirc N	
Dopamine	OYONOU	Global abnormaliti		O Y	_	
Dobutamine	O Y O N OU	Coronary angiogram:		O Y		
DDAVP	O Y O N OU	If Yes, normal:		O Y		
Other, specify:		If abnormal, number of	f vessels with	01	O 2	O 3
Other, specify:		> 50% stenosis:	i vesseis with	O i	02	<u> </u>
Other, specify:		Inotropic support:		ΟY	ΟN	
Cirici, specify.		If Yes, list the agents	used at acceptant	-		
Serology		procurement:	useu at acceptant	c and at	uiiie oi	
Anti-HIV I	P N U ND I C	·				
Anti-HIV II	P N U ND I C	At Acceptance:				
Anti-HTVL I	P N U ND I C	Agent	Dosage (mg/kg/min)	Time S		
Anti-HTVL II	P N U ND I C		(mg/kg/min)	(military	une)	
RPR-VDRL	P N U ND I C	1				
Anti-CMV	P N U ND I C	2				
HBsAg	P N U ND I C	3				
Anti-HBC	P N U ND I C	4				
Anti-HCV	P N U ND I C					
Donor Management (Pretreatment medication	ons given after brain death	At Time of Procurem				
declared and 24 hours prior to procurement)		Agent		Time S		
Did donor receive prerecovery medication:	\bigcirc Y \bigcirc N \bigcirc U		(mg/kg/min)	(military	time)	
If Yes, check Yes, No or Unknown for e	ach of the following:	1				
Steriods	OY ON OU	2				
Diuretics	OY ON OU	3				
T3	OY ON OU	4				
T4	OY ON OU					
Other, specify:	J . J J .			_	_	
Other, specify:		Right heart catheteriza	tion:	\bigcirc Y	\bigcirc N	
Other, specify:		If Yes:				
Other, specify:		CVP	PCW Pre	essure		
Other, specify.		PA Systolic	CO			
Transfusion units prior to surgery: (This hos	spitalization)	PA Diastolic				
	0 O Unk	Biopsy Performed:				
Transfusion units intraoperatively:	=	○ No Biopsy				
	0 O Unk	Yes, Myocarditis				
Three or more inotropic agents at time		Yes, Negative Biop	sy Result			
of incision:	J. J.,	Yes, Other Diagno	•			
Cardiac arrest since neurological event	OY ON	_				
that lead to declaration of brain death:	<u> </u>					
If Yes, duration of resuscitation:	min					
100, adiation of roodonation.						
LINOS/DUS/LICEA A/20/00				_	_	

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Lifesty of place tisk is months		Name:				Page 3 of 4
Caparette Use (> 20 pack years) Ever	Donor History				Lifestyle Factors:	
AND continued in last six months AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U Other Thug Use -Ever AND continued in last six months Y N N U History of Diabetes: If Yes, found the state of the stat					History of prison	OY ON OU
AND continued in last six months AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U AND continued in last six months Y N N U W AND continued in last six months Y N N U W AND continued in last six months Y N N U W AND continued in last six months Y N N U W AND continued in last six months Y N N U W W N W W W W W W W W W W W W W W	Cigarette Use (> 20 pack years) -Ever	OY	\bigcirc N	ΟU	Tattoos	OY ON OU
AND continued in last six months Y	AND continued in last six months				Sexual promiscuity	OY ON OU
AND continued in last six months	Alcohol Dependency -Ever	\bigcirc Y	\bigcirc N	ΟU	Other:	
	AND continued in last six months	s OY	\bigcirc N	\bigcirc \cup		
AND continued in last six months OY N U AND continued in last six months OY N U U AND continued in last six months OY N U U AND continued in last six months OY N U U AND continued in last six months OY N U U AND continued in last six months OY N U U AND continued in last six months OY N U U History of Diabetes: If Yes, how long: O-9-Years						
AND continued in last six months			_			-
Other Drug Use -Ever					Organ Recovery	
Non-Heart beating donor:					Recovery Date (donor to OR):	
					, , ,	
History of Diabetes:	AND continued in last six months	s () Y	ΟN	\bigcirc \Box	-	
If Yes, duration:	History of Diabetes:	ΟY	ΟN	Ου		
Clamp date:		_	_			
If Yes, how long:	O-5 Years O 6-10 Years	O >10 Years	O Un	k		
History of Hypertension:		ΟY	ΟN		-	
History of Hypertension:		0 40 1/2	○	1.	Clamp time (Military time):	Time zone:
History of Hypertension:	O 0-5 Years O 6-10 Years				Left Kidney Biopsy:	Right Kidney Biopsy:
0-5 Years		ΟY	\bigcirc N	\bigcirc \cup	\bigcirc Y \bigcirc N	ŎY ON
If Yes, method of control:		_	<u> </u>			
Diet	O-5 Years O 6-10 Years	○ >10 Years	O Unl	k		
Dituretics		_	_		■	
State	- 1					
Pump: Y N Pump: Y N N Pump: Y N N Pump: Y N Pump: Pump: Y N Pump: Y N Pump: Y N Pump: Pump: Pump: Pump: Pump: Pump						
History of Cancer: If Yes, cancer free interval	Other Hypertensive Medication	_	_			
If Yes, Primary site: (Select one) Skin Squamous, basal cell Oklaimore			\bigcirc N	\bigcirc \cup		
Skin		years.				
Squamous, basal cell CNS Tumor Astrocytoma Glioblastoma multiforme Medulloblastoma Astrocytoma Glioblastoma Meningioma Glioblastoma Meningioma Glioblastoma Medulloblastoma Angioblastoma Genitourinary Medulloblastoma Meningioma Meningiona Meningiona Meningiona Meningiona Meningiona Meningiona Meningion Meningiona Meningion Meni						
CNS Tumor					•	
Glioblastoma multiforme Intracranial surgery Medulloblastoma Intracranial no surgery Neuroblastoma CNS Other Orarian Orari) molarionia			ппл	ппинд
Medulloblastoma ☐ Intracranial no surgery Neuroblastoma ☐ CNS Other Angioblastoma ☐ CNS Other Genitourinary ☐ Ovarian ☐ Uterine Cervix ☐ Penis, Testicular ☐ Uterine body ☐ Kidney Choriocarcinoma ☐ Unknown genitourinary ☐ Vulva ☐ Colo-rectal ☐ Stomach ☐ Liver & biliary tract ☐ Breast ☐ Thyroid ☐ Tongue/Throat ☐ Larynx ☐ Lung (include bronchial) ☐ Leukemia/Lymphoma ☐ Other, specify: Cancer at procurement ☐ Y N U Intracranial ☐ Y N U Extracranial ☐ Y N U Extracranial ☐ Y N U ☐ Y N U Extracranial ☐ Y N U ☐ N O U ☐ Y N U ☐ N O U ☐ Y N U ☐ N Ovarian ☐ Y N U ☐ Pertusion pressure Systolic: _ mm/Hg Perfusion pressure Diastolic: _ mm/Hg Perfusion pressure Diastolic: _ mm/Hg Perfusion pressure Diastolic: _ mm/Hg Left Lung: _ Left Lung: Bronchoscopic abnormalities: _ Y N If Yes, Infiltrate: _ Y N If Yes, purulent drainage: _ Y N If Yes, purulent drainage: _ Y N Chest X-ray abnormalities: _ Y N If Yes, Infiltrate: _ Y N The Arrange of the Arra					Liver biopsy:	\bigcirc Y \bigcirc N
Neuroblastoma					•	_
Angioblastoma Genitourinary Bladder Utterine Cervix Penis, Testicular Perfusion pressure Systolic:mm/Hg Perfusion pressure Diastolic:mm/Hg Perfusion pressure Systolic:mm/Hg Perfusion pressure Diastolic:mm/Hg Perfusion pressure Diastolic:mm/Hg Perfusion pressure Diastolic:mm/Hg Perfusion pressure Diastolic:mm/Hg Perfusion pressure Systolic:mm/Hg Perfusion pressure Diastolic:mm/Hg				gery	-	
Genitourinary		CNS Other				-
Bladder Uterine Cervix Penis, Testicular Prostate Uterine body Endometrial Uterine body Choriocarcinoma Unknown genitourinary Vulva Gastrointestinal Esophageal Stomach Small Intestine Breast Thyroid Tongue/Throat Larynx Lung (include bronchial) Leukemia/Lymphoma Other, specify: Cancer at procurement Intracranial Extracranial Cancer at procurement Extracranial Esophageal Ovarian Flow rate: Ccc's/min Perfusion pressure Systolic: mmm/Hg Perfusion pressure Diastolic: mmm/Hg Perfusion pressure Diastolic: mm/Hg Perfusion pressure Systolic: mmm/Hg Perfusion pressure Systolic: mm/Hg Perfusion pressure Diastolic: mm/Hg Perfusion pressure Systolic: polocy Perfusion pressure Diastolic: polocy Perfusion pressure Diastolic: polocy Perfusion pressure Systolic: Perfusion pressure Systolic: polocy Perfusion pressure Systolic: polocy Perfusion pressure Systolic: polocy Perfusion pressure Systolic: Perfusion pressure Sister Perfusion pressure Diastolic: Perfusion pressure Jeau press						
Uterine Cervix Uterine body Endometrial Uterine body Choriocarcinoma Vulva Gastrointestinal Esophageal Stomach Small Intestine Breast Thyroid Tongue/Throat Larynx Lung (include bronchial) Leukemia/Lymphoma Other, specify: Cancer at procurement Intracranial Extracranial Uterine body Kidney Choriocarcinoma Vulva Call Refusion pressure Systolic: mm/Hg Perfusion pressure Systolic: perfusion pressure Systolic: mm/Hg Perfusion pressure Systolic: mm/Hg Perfusion pressure Systolic: perfusion pressure Systolic: mm/Hg Perfusion pressure Systolic: perfusion pressure Systolic: perfusion pressure Systolic: perfusion pressure Systolic: perfusion pressure Diastolic: mm/Hg Perfusion pressure Systolic: perfusion pressure Sistolic: perfusion pressure Sistolic: perfusion pressure Diastolic: mm/Hg Perfusion pressure Sistolic: policies Sistolic: perfusion pressure Sistolic: perfusion pressure Sistolic: perfusion pressure Sistolic: policies Sistolic: perfusion pressure Sistolic: perfusion pressure Sistolic: policies Sistolic: policies Sistolic: perfusion pressure Sistolic: policies Sistolic: perfusion pressure Sistolic: policies Sistolic Sis		Ovarian				
Uterine body Choriocarcinoma			icular			
Choriocarcinoma						
O Vulva Gastrointestinal ○ Esophageal ○ Colo-rectal ○ Stomach ○ Liver & biliary tract ○ Small Intestine ○ Pancreas ○ Breast ○ Thyroid ○ Tongue/Throat ○ Larynx ○ Lung (include bronchial) ○ Leukemia/Lymphoma ○ Other, specify: Cancer at procurement Intracranial ○ Y ○ N ○ U Extracranial ○ Y ○ N ○ U Extracranial ○ Y ○ N ○ U If Yes, purulent drainage: ○ Y ○ N Chest X-ray abnormalities: ○ Y ○ N If Yes, purulent drainage: ○ Y ○ N Chest X-ray abnormalities: ○ Y ○ N If Yes, purulent drainage: ○ Y ○ N Chest X-ray abnormalities: ○ Y ○ N If Yes, purulent drainage: ○ Y ○ N Chest X-ray abnormalities: ○ Y ○ N If Yes, purulent drainage: ○ Y ○ N If Yes, purulent drainage: ○ Y ○ N If Yes, purulent drainage: ○ Y ○ N			onitouri	non/	Lung	
Gastrointestinal Esophageal		Unknown g	CHILOUIT	ııaıy		
☐ Esophageal ☐ Colo-rectal ☐ Stomach ☐ Liver & biliary tract ☐ Small Intestine ☐ Pancreas ☐ Breast ☐ Y ☐ N ☐ Thyroid ☐ Chest X-ray abnormalities: ☐ Tongue/Throat ☐ Y ☐ N ☐ Larynx ☐ Lung (include bronchial) ☐ Leukemia/Lymphoma ☐ Other, specify: ☐ Cancer at procurement ☐ Y ☐ N ☐ U Intracranial ☐ Y ☐ N ☐ U Extracranial ☐ Y ☐ N ☐ U Extracranial ☐ Y ☐ N ☐ U If Yes, Infiltrate: ☐ Y ☐ N Chest X-ray abnormalities: ☐ Y ☐ N ☐ If Yes, Infiltrate: ☐ Y ☐ N ☐ If Yes, Infiltrate: ☐ Y ☐ N						
Small Intestine	Esophageal					\bigcirc \lor \bigcirc \bigcirc \bigcirc
○ Breast ○ Thyroid ○ If Yes, Infiltrate: ○ Y ○ N ○ Tongue/Throat ○ Larynx ○ Lung (include bronchial) ○ Leukemia/Lymphoma ○ Other, specify: ○ Cancer at procurement ○ Y ○ N ○ U ○ Y ○ N ○ Y ○ N Intracranial ○ Y ○ N ○ U ○ Y ○ N ○ Y ○ N Extracranial ○ Y ○ N ○ U ○ Y ○ N ○ Y ○ N If Yes, Infiltrate: ○ Y ○ N ○ Y ○ N If Yes, Infiltrate: ○ Y ○ N ○ Y ○ N			ary tract			9 9
○ Thyroid ○ Tongue/Throat ○ If Yes, Infiltrate: ○ Y ○ N ○ Larynx ○ Lung (include bronchial) ○ Leukemia/Lymphoma ○ Other, specify: ○ Other, specify: ○ Other, specify: ○ Y ○ N ○ U Intracranial ○ Y ○ N ○ U ○ Y ○ N Extracranial ○ Y ○ N ○ U ○ Y ○ N If Yes, Infiltrate: ○ Y ○ N Chest X-ray abnormalities: ○ Y ○ N If Yes, Infiltrate: ○ Y ○ N If Yes, Infiltrate: ○ Y ○ N	l ~ -	O Pancreas			• • • • • • • • • • • • • • • • • • • •	
○ Tongue/Throat If Yes: □ Upper □ Mid □ Lower ○ Larynx ○ Lung (include bronchial) ○ Leukemia/Lymphoma Bronchoscopic abnormalities: ○ Y ○ N ○ Other, specify: □ If Yes, purulent drainage: ○ Y ○ N Cancer at procurement Y ○ N ○ U Intracranial Y ○ N ○ U Extracranial Y ○ N ○ U If Yes, Infiltrate: ○ Y ○ N					-	
Clarynx Clung (include bronchial) Cleukemia/Lymphoma Bronchoscopic abnormalities: Cancer at procurement Y N U Intracranial Y N U Extracranial Y N U If Yes, Infiltrate: Y N Intracranial If Yes, Infiltrate:					·	
Lung (include bronchial) Leukemia/Lymphoma Other, specify: Cancer at procurement Intracranial Extracranial OY ON OU Extracranial OY ON OU Extracranial OY ON OU If Yes, Infiltrate: OY ON U If Yes, Infiltrate: OY ON U If Yes, Infiltrate: OY ON						ıvılu 🔛 Lower
Other, specify: Cancer at procurement Intracranial Extracranial OY ON OU Extracranial OY ON OU If Yes, purulent drainage: OY ON U If Yes, purulent drainage: OY ON U If Yes, Infiltrate: OY ON	Lung (include bronchial)					
Cancer at procurement Intracranial Extracranial OY ON OU Extracranial OY ON OU If Yes, Infiltrate: OY ON If Yes, Infiltrate:					•	
Intracranial OY ON OU Extracranial OY ON OU If Yes, Infiltrate: OY ON						
Extracranial OY ON OU If Yes, Infiltrate: OY ON		\cap	\bigcirc N	\bigcirc \Box	Chest X-ray abnormalities:	
					If Yes, Infiltrate:	OY ON
				ŎŬ	If Yes:	Mid Lower

UNOS/PHS/HCFA 1/28/00

Person completing form:

Date completed: ____

Cadaver Donor Registration Form

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

	Name:		Page 4 of 4
Kidney Right -		Liver Segment 2 -	
· ·	Other Specify:		Other Specify:
Discard Code:	Other Specify:		Other Specify:
Recov. Team #	Placed by: Type Share:	Recov. Team #	Placed by: Type Share:
Flush Solution:	Other Specify:	Flush Solution:	Other Specify:
	Other Specify:	Storage Solution:	Other Specify:
Recipient Name SSN	Provider # - Center Code - Tx Center Name	Recipient Name SSN	Provider # - Center Code - Tx Center Name
Kidney Left -	1 Tovider # - Genter Gode - 1x Genter Name	Intestine -	Flovider # - Certer Code - 1x Certer Name
_	Other Specify:		Other Specify:
	Other Specify:		· · · · ·
	Placed by: Type Share:		Placed by: Type Share:
	Other Specify:		Other Specify:
	Other Specify:		Other Specify:
Recipient Name SSN	Provider # - Center Code - Tx Center Name	Recipient Name SSN	Provider # - Center Code - Tx Center Name
Kidney Double/Enbloc		Intestine Segment 1-	01 0 1
	Other Specify:		Other Specify:
Discard Code:	Other Specify:		
Recov. Team #	Placed by: Type Share:	Recov. Team #	Placed by: Type Share:
	Other Specify:		
Storage Solution:	Other Specify:	Storage Solution:	Other Specify:
Recipient Name SSN	Provider # - Center Code - Tx Center Name	Recipient Name SSN	Provider # - Center Code - Tx Center Name
Pancreas -		Intestine Segment 2 -	
Reason Code:	Other Specify:	Reason Code:	Other Specify:
Discard Code:	Other Specify:		Other Specify:
Recov. Team #	Placed by: Type Share:	Recov. Team #	* * * * * * * * * * * * * * * * * * * *
Flush Solution:	Other Specify:		Other Specify:
Storage Solution:	Other Specify:	Storage Solution:	Other Specify:
Recipient Name SSN	Provider # - Center Code - Tx Center Name	Recipient Name SSN	Provider # - Center Code - Tx Center Name
Pancreas Segment 1 -		Heart -	
Reason Code:	Other Specify:	Reason Code:	Other Specify:
Discard Code:	Other Specify:	Discard Code:	Other Specify:
Recov. Team #	Placed by: Type Share:	Recov. Team #	Placed by: Type Share:
Flush Solution:	Other Specify:	Flush Solution:	Other Specify:
Storage Solution:	Other Specify:	Storage Solution:	Other Specify:
Recipient Name SSN	Provider # - Center Code - Tx Center Name	Recipient Name SSN	Provider # - Center Code - Tx Center Name
Pancreas Segment 2 -	Tronds in Control Code Troother Name	Lung Right -	Trovidor ii Contor Codo TX Contor Hame
	Other Specify:		Other Specify:
	Other Specify:		
	Placed by: Type Share:		Placed by: Type Share:
	-		Other Specify:
	Other Specify:	Storage Solution:	
Davisiest News	Paraida III. Oratos Orde To Oratos Nassa	2001	
Recipient Name SSN Liver -	Provider # - Center Code - Tx Center Name	Recipient Name SSN	Provider # - Center Code - Tx Center Name
-	Other Specific	Lung Left -	Other Coesifu
Discard Code:	Other Specify:	Discard Code:	Other Specify:
Recov. Team #	Placed by: Type Share:		Placed by: Type Share:
	Other Specify:		Other Specify:
	Other Specify:		Other Specify:
Recipient Name SSN	Provider # - Center Code - Tx Center Name	Recipient Name SSN	
Liver Segment 1 -		Lung Double/En-bloc -	
	Other Specify:		Other Specify:
	Other Specify:		Other Specify:
	Placed by: Type Share:	Recov. Team #	
	Other Specify:		Other Specify:
Sidiage Solution:	Other Specify:	Storage Solution:	Other Specify:
Recipient Name SSN	Provider # - Center Code - Tx Center Name	Recipient Name SSN	Provider # - Center Code - Tx Center Name

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Person completing form: _____

Cadaver Donor Referral Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

				Page 1 of 1
Provider Information			Date of Referral call:	
OPO Provider Number Center Code OPO Ce	enter Name	Donor Hospital Provider Number	Donor Hospital Name	
Donor Information			UNOS Donor ID:	:
Name:	First	DOB:	If Unknown, give	e age:
Gender: Male Female	Home City:	State:	: Home Zip Code	e:
Ethnicity O Hispanic/Latino	O Non-Hispanic/Non-Latino	Was Death reported to No	Medical Examiner/Coroner	:
Race	_	Medical examiner	r consented	
O White	Native Hawaiian or	Medical examiner		
Black or African American American Indian or Alaska	other Pacific Islander Mid-East or Arabian	○ Unknown	_	
Native	Indian Sub-Continent	Was the donor's wish to	_	ON OU
Asian	O Unknown		rior to donation request: lation request made: (Selec	ot anal
		No	iation request made. (Selec	orie)
Citizenship (Select one) U.S. Citizen	O Decident Alien	Yes, family initiate	ed	
Non-Resident Alien, specify cou	Resident Alien	O Approached by p		
Home country:	=	O Approached by n		
O Unknown		O Approached by cl		
Cause of Death (Select one)		Approached by OApproached by S		
Anoxia/Cardiac Arrest	O Head Trauma	Other, Specify:		
Cerebrovascular/Stroke	O CNS Tumor	-	in donation obtained by: (S	Select one)
Other, specify:		O No consent obtain		
Mechanism of Death (Select one)		OPO Coordinator	_	
O Drowning	O Stab	Social WorkerOther, specify:	Clergy	
O Seizure	O Blunt Injury		anlaly on OV	
O Drug Intoxication	O Sudden Infant Death	Was the consent based written documentation		○N
Asphyxiation	O Intracranial Hemorrhage	If Yes, indicate mecha	•	
Cardiovascular Electrical	/Stroke O Death from Natural	☐ Driver's license	Living will	
Gunshot Wound	Causes	☐ Donor card	☐ Attorney in face	et
None of the Above		☐ Donor registry		
		Other, specify:		
Circumstances of Death (Select one)				
Motor Vehicle Accident	ODeath from Natural			
Alleged Suicide	Causes			
O Alleged Homicide	ONone of the Above			
Alleged Child AbuseNon-Motor Vehicle Accident				
Procurement and Consent				
Was donor suitable for procurement	of organs: OYON			
If No, select one primary reason: HIV +	Modical History			
O HCV +	Medical History Social History			
O Hepatitis B +	O Cancer			
O Tuberculosis	○ Age			
O Brain death criteria not met				
Other, specify:				
LINOS/DUC/LICEA A/00/00				

UNOS/PHS/HCFA 1/28/00

Person completing form: ___

Living Donor Registration (Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

								ray	erori
Provider Information									
Provider Number Center Code Recipient	Transplant Cent	er Name							
Donor Information					Donor	r ID:			
Name:	First					plant Date:			
DOB: S				Gender: O M	lale 🔾	Female Blood	Type: _		Rh:
Home City: H				Home Zip Code					
Living Donor Type: (Indicate the relation	ship of the d	onor to th	е	Clinical Info	rmati	ion			
recipient by checking one.)				Height	ft.	in. O	R		cm
Living, Biologically Related Parent				Weight	lbs	. О	R		kg
O Child				Serology					
Identical TwinFull Sibling (Not Identical Twin)				HIV		Screening			DIC
O Half Sibling				CMV		Confirmation IgG		U NI U NI	D I C
Other Relative, specify:				CIVIV		IgM		UNI	
Living, Biologically Unrelated Spouse				Hanatitia D		DNA			DIC
Other, specify:				Hepatitis B		Core Antibody Surface Antigen			D I C
	<u> </u>					HBV DNA	PΝ	U NI	DIC
Ethnicity	O Non-H	ispanic/N	on-Latino	Hepatitis C		Antibody Screen RIBA Test		U NI U NI	
Race	O					HCV RNA			DIC
White Black or African American	Native	Hawaiia Pacific I		Epstein Barr \	/irus	IgG		U NI	
American Indian or Alaska) Mid-Ea					IgM DNA		U NI U NI	
Native	O Indian							- 11	
◯ Asian				Creatinine: (Kidr Preoperative:					
Citizenship (Select one)				At Discharge:					
U.S. Citizen	Reside	ent Alien		Kidney Procedu	ire Typ	e:			
O Non-Resident Alien, specify cour Home country:	=			Transabdo					
riome country.				LaparoscoFlank	opic				
Highest Education Level (Select one)				Blood Pressure	(mmH	a)			
O None		ate/Bach	nelor	Systolic Preor	perative	e: Systoli	c at Dis	charge	:
○ Grade School (0-8)○ High School (9-12)	Degr O Post-C		iraduate	Diastolic Preo	perativ	e: Diasto	lic at Di	scharge	e:
Attended College/Technical	Degr		raaaato			y: days			
School	Unkno	wn		Bleeding requir		nstusion:) 6-10	Unk		
Source of Payment	dom: 00:1100	of norman	.4\	Infections durin				() Y	\bigcirc N
(Check Yes, No or Unknown for each second Primary (Largest %, Select one)		econdar		Pulmonary Emb	olism	during hospitaliza		ΟY	ŌΝ
		•	_			overy of donor or	gan:	○ Y	\bigcirc N
Medicare Medicaid	() Y () Y	\bigcirc N	Ου Ου	Date of Death: _ Cause of Dea		Donation Related	Othe	er Caus	e
US/State Government Agency	OY	\bigcirc N	ΟU	Organ Reco					
Private Insurance	ΟY	○ N	ΟU	Recovered outsi		_	reiy Da ○ Y	.e	
○ HMO/PPO	(Y	\bigcirc N	OU			0.5.	_	O IN	
○ Self	\bigcirc Y	\bigcirc N	\bigcirc U		,				
ODonation	○ Y	O N	ΟU	Donor Recovery Facility					
Free Care	○ Y	○ N	ΟU	Donor Workup Facility					
Dept. of Veterans AffairsPending				Organia) Barri	Deci-1	Name Les			
Foreign Govt. Specify:				Organ(s) Recovered Recipient SSN	Recipient	Name: Last		Firs	
5 - 5.5.g.: 001 Opening.				Veribieur 2017					

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Person completing form: ____

Date completed: ___

Living Donor Follow-Up (Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

		Page 1 of 1
Provider Information		
Tx Provider Number Center Code Tx Center Name		
Follow-up Number Center Code Follow-up Center Name		
Donor Information		
Name:	Donor ID:	
Recovery Date: DOB:	_ SSN: Gend	der: O Male O Female
Patient Status		
Date: of Report, Last Seen or Death Living Dead Lost to Follow-Up		
Cause of Death: ODonation Related Other Cause		
Clincial Information		
Height ft in. OR cm		
Weight lbs. OR kg		
Blood Pressure at Follow-Up: Diastolic: mmHg		
Serum Creatinine: mg/dl Complications: Antihypertensive Drugs (specify) Any Non-maintenance Dialysis Maintenance Dialysis Added to UNOS kidney transplant candidate waiting list Liver Donor mg/dl		

UNOS/PHS/HCFA 1/28/00

Person completing form: ___

Date completed: ____

Donor Histocompatibility Form (Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Page 1 of 1

					rage rorr
Provider Information					
OPO Provider Number Center Code	OPO Center Name				
Lab Provider Number Center Code	Lab Name				
Donor Information					
_			Donor Type		
UNOS Donor ID Donor Name: Last	First				
Donor Center Histoco	mpatibility Typing				
Was HLA typing performed on t					
OY ON C					
Date Typed: If donor HLA typed, complete		tion.			
If donor was not HLA typed of			return the form.		
Target Source: (Select one)					
Peripheral Blood Lympho	ocytes	ОМ	ultiple		
Lymph Nodes		_	nymocytes		
O Spleen		O c	ell lines/Clonal Cells		
O Solid Matrix					
Typing Method Class I:			Typing Method Class II:		
SerologyOther, specDNA	ify:		○ Serology ○ Other, sp○ DNA	ecify:	
O DINA			O DINA		
A:	Bw4:		DR:	DQ:	
A:	Bw6:		DR:	DQ:	
B:	Cw:		DR51: DR52:	DPw:	
B:	Cw:		DR52:	DFW.	
			21.00.		
Recipient of a Living I	Donor Information				
Living Recipient Name: Last	First		SSN:	Organ:	
Tx Provider Number: Center Code:	Tx Center Name:				
Haplotype Match Information:		~	O		
0 0.5 01	O 1.5 O 2	O Unk	N/A Donor Not Typed		

UNOS/PHS/HCFA 11/9/00

Person completing form: __

Recipient Histocompatibility Form

(Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002 Page 1 of 1 Provider Information Lab Provider Number Center Code Lab Center Name Tx Provider Number Center Code Tx Center Name Recipient Information Organ(s): _____ Name: ____ _ Transplant Date: _____ First SSN: ___ _____ Gender: O Male O Female DOB: __ HIC: ____ **Donor Information Section III - Crossmatch** Donor Type: A. Most Recent Serum Date: Cell Type: Target Source: Technique: Result: UNOS Donor ID Donor Name: Last First Test Information HLA typing done: $\bigcirc Y$ \bigcirc N If Yes, complete Section I. PRA testing done: \bigcirc Y \bigcirc N If Yes, complete Section II. Auto Crossmatch positive: O Y O N O Not done O U Crossmatch done: \bigcirc N If Yes, complete Section III. Donor retyped at your center: \bigcirc Y \bigcirc N B. Positive Crossmatch with any other sera by any other If Yes, complete Section IV. O_{Y} Section I - Recipient HLA Typing If Yes, give most recent positive Serum Date(s): Serum Date: Cell Type: Target Source: Technique: Result: Date Typed: _____ Cell Source: ___ (Use code) Typing Method Class I: O Serology Other, specify: ___ O DNA A: Bw4: Auto Crossmatch positive: O Y O N O Not done O U A: Bw6: Cw: B: **Section IV - Donor Retyping** B: Cw: Date Typed: ___ Typing Method Class II: Cell Source: ___ O Serology O Other, specify: (Use code) O DNA Typing Method Class I: DR: DQ: ○ Serology ○ Other, specify: _____ DR: DQ: O DNA DR51: DPw: A: Bw4: DR52: DPw: A: Bw6: DR53: B: Cw: Section II - Panel Reactive Antibody (%PRA) B: Cw: Most Recent Serum Date: _____ Typing Method Class II: O Serology O Other, specify: Cell Type: Cell Source: Technique: PRA%: O DNA DR: DQ: DR: DQ: Peak Serum Date: ___ DR51: DPw: Cell Source: Technique: Cell Type: PRA%: DPw: DR52:

DR53:

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Person completing form:

Kidney Transplant Recipient Follow-Up Form (Please print or type all information) FORM APPROVED: O.M.B. NO.

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

	Page 1 of 2				
Provider Information Provider Number Center Code Transplant Center Name	Follow-Up care provided by: Transplant Center Non-Transplant Center Specialty Physician				
Follow-Up Provider Number Center Code Follow-Up Center Name	Primary Care Physician (HMO/PPO) Other, specify:				
Physician Name Physician UPIN					
·	City State Zip				
Recipient Information	Transplant Date:				
Name:	Discharge Date:				
DOB: SSN:	HIC: Gender: O Male O Female				
Donor Information Donor Type:	Employment Status (Select one) (Working = Employed, Home, School) Working Full Time				
UNOS Donor ID Donor Name: Last First	○ Working Part Time By Choice				
Patient Status at Time of Follow-Up (Select one)	Working Part Time Due to Disease				
Date: Patient Report, Death or Retransplant	○ Working Part Time, Reason Unknown				
Living	O Not Working By Choice				
O Dead Cause of Death:	O Not Working Due to Disease				
(Use code)	 Not Working, Unable to Find Employment Not Working, Reason Unknown 				
Specify:	Retired				
C Lost to Follow-Up	Employment Status Unknown				
Retransplanted since last Follow-Up	Patient Less Than Five Years Old				
Patient transferred to new provider: OYON					
If Yes, transferred to UNOS member OYON	Clinical Information				
Transfer Date:	Height ft in. OR cm				
New Provider Number New Provider Name	Weight lbs. OR kg				
	Graft Status				
Hospitalizations during follow-up period: OYONOU Number of transplant related hospitalizations:	Dialysis since last follow-up:				
	Resumed maintenance dialysis OYON U				
Was patient in ICU:	If Yes, date resumed:				
Noncompliance	Dialysis center provider #:				
Patient noncompliant during follow-up period: OYONOU	Dialysis center name:				
If Yes, indicate areas of noncompliance	W				
☐ Immunosuppression medication	If functioning, most recent Serum Creatinine:mg/dl				
Patient unable to afford immunosuppression medications	If failed, failure date:				
Uther medication					
Other medication, specify: Other therapeutic regimen	Cause of graft failure (Check Yes, No or Unknown for each				
Other therapeutic regimen, specify:	contributory cause of graft failure) Primary (Check one) Contributory				
	Acute rejection Y N U				
Functional Status at Follow-Up (Select one) (How does the patient	○ Chronic rejection ○ Y ○ N ○ U				
perform activities of daily living?)	O Primary failure				
No activity limitations. (NYHA Class I or Class II)	○ Graft thrombosis ○ Y ○ N ○ U				
Performs activities of daily living with some assistance.	O Infection O Y O N O U				
(NYHA Class III)	○ Urological complications○ Recurrent disease○ Y○ N○ U				
O Performs activities of daily living with total assistance.	Other: Other:				
(NYHA Class IV)	O Union				
N/A Patient hospitalized Unknown					
O Silkilowii					

Kidney Transplant Recipient Follow-Up Form FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

	Name:			Page 2 of 2
Patient treated for re	ejection: O Y	\bigcirc N	\bigcirc U	
Number of rejection	n events:			
Canalague				
Serology	One and in the	II ND		
HIV	Screening P N Confirmation P N	U ND U ND	I C	
CMV	IgG P N	U ND	I C	
Olviv	IgM P N	U ND	I C	
	DNA P N	U ND	I C	
Hepatitis B	Core Antibody P N	U ND	I C	
	Surface Antigen P N	U ND	I C	
Hamatitia C	HBV DNA P N	U ND	I C	
Hepatitis C	Antibody Screen P N RIBA Test P N	U ND U ND	I C	
	HCV RNA P N	U ND	I C	
Epstein Barr Virus	IgG P N	U ND	I C	
,	IgM P N	U ND	I C	
	DNA P N	U ND	I C	
Post transplant mali	gnancies*	○ N	(U	
=	pe of Malignancy only once in the	~	-	
Donor related	Or Wanghancy only once in the		O U	
Recurrence of pre-t		○ N	ΟŪ	
Post Tx De Novo so		ŌΝ	Ο̈́U	
	liferative Disease and Lymp	_	_	
, , ,	ΟY	\bigcirc N	\bigcirc U	
* If Yes complete P	ost Transplant Malignancy	, form		
ii res, complete i	ost Transplant Manghancy	, 101111.		
Treatment				1
Immunosuppressive	Information			
	given during the follow-up	(Y	\bigcirc N	
period for maintenance or anti-rejection:		<u> </u>	0	
If no maintenance medications are currently		ΟY	\bigcirc N	
given, did the phys	sician discontinue all			
immunosuppressiv				
Did the patient particip		\bigcirc Y	\bigcirc N	
-	or immunosuppressive medi	cations:		
If Yes, specify:				
O.1 TI				
Other Therapy		\bigcirc \vee		
Photopheresis		\bigcirc Y	\bigcirc N	
Plasmapheresis Total Lymphoid Irra	diation (TLI)	○ Y ○ Y	\bigcirc N	
Total Lymphold illa	uiation (TLI)	\bigcirc 1	O N	
Biologicals/Vaccines	<u> </u>			
Cytogam (CMV)		() Y	\bigcirc N	
Gamimune N 10%		ΟY	\bigcup N	
Gammagard SD		\bigcirc Y	\bigcirc N	
Acyclovir (Zovirax)		O Y	○ N	
Ganciclovir (Cytover	ne)	O Y	○ N	
HBIG (Hepatitis B Im		○ Y	\bigcirc N	
Flu Vaccine (Influenz		○ Y	\bigcirc N	
	za viius)		U 11	
Ouidi				
				1

UNOS/PHS/HCFA 3/29/01

Person completing form: ___

Date completed: ___

Immunosuppression Treatment Follow-Up (Please print or type all information) FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2002

Page 1 of 1

MI			
	December Transport		
	Donor Type: _		
All Maint	Maint		
since last	at time	Anti-rej	
report	of report		
		\sqsubseteq	
		Ш	
		Ц	
		Ц	
Ш		Ы	
Ш		Ш	
_			
	All Maint since last report	All Maint since last report of report	All Maint since last at time Anti-rej report of report

UNOS/PHS/HCFA 11/30/00

Person completing form: _