

SPLIT			
\$sitecode	User:	System Date:	Mode: Development
Site Name:			

Transplant Baseline (TPP)

Version: 6.0; 12-26-07

Segment (*PROTSEG*):Visit Number (*VISNO*):

Transplant date:

All information reported on the Transplant Baseline form should reflect the time period within 48 hours prior to transplant unless otherwise specified below.

Status and Listing Information

1. UNOS Status 1a or 1b: (*TPPUNOS*) ☐ No - 0 ☐ Yes - 1

2. Canadian Status 4 or 4f (equivalent to UNOS Status 1): (*TPPUNOS*) ☐ No - 0 ☐ Yes - 1

If yes, complete Status 1 Listing form.

a. Indicate score type used to list with UNOS: (*TPPScore*) ☐ PELD - 1 ☐ MELD - 2

b. Was the calculated score or exception score used to list the participant? (*TPPALLOC*) ☐ Calculated - 0 ☐ Exception - 1

PELD exception score: (*TPPELDA*) _____ (xxx.x)

MELD exception score (if ≥ 12 years): (*TPPELDA*) _____ (xxx.x)

3. Patient status: (*TPPSTAT*)

ICU - 1
Hospitalized, not in ICU - 2
Not hospitalized - 3

If Status 1- ICU, please code the following:

Intubated: (*TPPICINT*) ☐ No - 0 ☐ Yes - 1

Is the patient on artificial or extracorporeal support? (*TPPARTIF*) ☐ No - 0 ☐ Yes - 1

Does the participant have encephalopathy: (*TPPICENC*) ☐ No - 0 ☐ Yes - 1

If Yes, please specify stage _____ (x)

(1-4): (TPPENCST)

Labs/Procedures

4. Hematology/ Chemistries (just prior to transplant):

	<u>Common Units (CU)</u>	<u>Standard International (SI)</u>
Total Bilirubin:	(TPPTOBIL) _____ (xxx.x) mg/dL	(TPPTBSI) _____ (xxxxx.x) μmol/L
AST/SGOT:	(TPPAST) _____ (xxxxx) U/L	(TPPASTSI) _____ (xxxxx) U/L
ALT/SGPT:	(TPPALT) _____ (xxxxx) U/L	(TPPALTSI) _____ (xxxxx) U/L
Albumin:	(TPPALB) _____ (xx.x) g/dL	(TPPALBSI) _____ (xxx.x) g/L
Total Cholesterol:	(TPPTCHOL) _____ (xxxx) mg/dL	(TPPTCHSI) _____ (xx.xxx) mmol/L
Triglycerides:	(TPPTRIGL) _____ (xxxx) mg/dL	(TPPTRISI) _____ (xxx.xx) mmol/L
Glucose:	(TPPGLUC) _____ (xxxx) mg/dL	(TPPGLUSI) _____ (xxx) mmol/L
Sodium:	(TPPSODCU) _____ (xxx) mEq/mL	(TPPSODSI) _____ (xxx) mmol/L
Serum Creatinine:	(TPPSRCRE) _____ (xx.x) mg/dL	(TPPSCSI) _____ (xxxx.x) μmol/L
WBC:	(TPPWBC) _____ (xxx.x) 10 ³ cells/μL	(TPPWBCSI) _____ (xxx.x) 10 ⁹ cells/L
Platelets:	(TPPPLAT) _____ (xxxx) 10 ³ cells/μL	(TPPPLTSI) _____ (xxxx) 10 ⁹ cells/L
Prothrombin time:	(TPPPROTM) _____ (xxx.x) seconds	
INR:	(TPPINR) _____ (xx.x)	

5. Recipient pretransplant viral screen:

Enter results from up to 90 days prior to transplant.

HCV: (TPPRHCV)

Positive - 0	<input type="checkbox"/>
Negative - 1	<input type="checkbox"/>
Not done - 2	<input type="checkbox"/>

CMV: (TPPRCMV)

EBV: (TPPREBV)

Positive - 0
 Negative - 1
 Not done - 2

Positive - 0
 Negative - 1
 Not done - 2

6. Number of prior liver
 transplants: (TPPRTRA) (x)

7. Is the participant on dialysis or
 hemofiltration? (TPPICDH) ☐ No - 0 ☐ Yes - 1

Renal Aim

8. Does the participant have any of
 the below primary renal diseases
 unrelated to calcineurin inhibitor
 exposure? (TPPRENAL) ☐ No - 0 ☐ Yes - 1

*Primary Renal Diseases: Vesicoureteral reflux, obstructive uropathy, renal hypo/dysplasia, cystic kidney,
 chronic glomerulonephritis, or other non-CNI disease.*

*Renal dysfunction secondary to primary liver disease and renal tubular dysfunction without decrease in
 GFR do not apply.*

If Yes, indicate
 type: (TPPRETYP)

Vesicoureteral reflux - 1
 Obstructive uropathy - 2
 Renal hypo-/dysplasia - 3
 Cystic kidney condition - 4
 Chronic glomerulonephritis - 5
 *Additional Options Listed Below

If Other,
 specify: (TPPREOTH)

Assessments

9. Height: (TPPHTND) ☐ Not Done
 (TPPHTDT) Date (mm/dd/yyyy)
 (TPPHT) Value (xxx.x) cm (TPPHTIN) (xx.x) in

10. Weight: (TPPWTND) ☐ Not Done
 (TPPWTDT) Date (mm/dd/yyyy)
 (TPPWT) Value (xxx.x) kg (TPPWTLBS) (xxx.x)

lbs

11. Head Circumference (if < 5 years): (TPPHCND)

☐ Not Done

(TPPHCDT)

Date _____ (mm/dd/yyyy)

(TPPHC)

Value _____ (xx.x) cm

12. Tanner stage (if ≥8 years):

Method of
assessment: (TPPTANME)

Self report - 1
Evaluation - 2
Not done - 9

Pubic: (TPPTANGE)

1
2
3
4
5

Breast: (TPPTANBR)

1
2
3
4
5

13. Primary payor: (TPPPAYOR)

Medicaid or equivalent and/or state funded children's services - 1
HMO/ managed care - 3
Traditional private insurance - 4
Champus (military) - 5
Self pay - 6
*Additional Options Listed Below

If *Other*, please
specify: (TPPOTHPY)

Donor Information

14. Donor age

If participant ≥ 2 years, record
age in years: (TPPDAGEY) _____ (xx) years

If participant < 2 years, enter 0
for years and record age in
months: (TPPDAGEM) _____ (xx) months

15. Donor ethnicity: (TPPDETHN)

Hispanic or Latino - 1
Not Hispanic or Latino - 2
Unknown - 9

16. Primary donor race: (TPPDRACE)

White or Caucasian - 1
Black or African American - 2
Asian - 4
Native Alaskan or American Indian - 5
Native Hawaiian or other Pacific Islander - 6
*Additional Options Listed Below

17. Donor sex: (TPPDSEX)

☐ Male - 1 ☐ Female - 2

18. Donor weight: (TPPDWT)

 (xxx.x) kg (TPPDWTLB) (xxx.x) lbs

19. Donor blood type: (TPPDBTYP)

A - 1
B - 2
O - 3
AB - 4

20. Donor pretransplant viral screen:

HCV: (TPPDHCV)

Positive - 0
Negative - 1
Not done - 2

CMV: (TPPDCMV)

Positive - 0
Negative - 1
Not done - 2

EBV: (TPPDEBV)

Positive - 0
Negative - 1
Not done - 2

The Notes field should not be used to communicate information to the SPLIT DCC. This field is intended to be used for notes center staff may find useful when returning to the form.

Notes: (TPPCOMME)

Additional Selection Options for TPP

If *Yes*, indicate type:

Other - 9

Primary payor:

Donation - 7

No funding - 8

Other - 99

Primary donor race:

Unknown - 9

