



## RCP GI Bleed Comp Severity

|  |   |                           |
|--|---|---------------------------|
| Date of Onset  |   |                           |
| Resolution of the complication within 3 months post-operatively. This does not apply to complications that are self-limiting acute events. | <input type="radio"/> Yes   |                           |
|  | <input type="radio"/> No  |                           |
|  | <input type="radio"/> Not Applicable  |                           |
|  | <input type="radio"/> Unknown   |                           |
| If No or N/A to Resolution, Complication worsened. (requiring intervention in an effort to control the complication or its sequelae)       | <input type="radio"/> Yes   |                           |
|  | <input type="radio"/> No  |                           |
| Medications Required for Treatment   | <input type="radio"/> Yes   |                           |
|  | <input type="radio"/> No  |                           |
| If yes to Medications Required for Treatment, Type of Medications  | <input type="radio"/> Routine Medications   |                           |
|  | <input type="radio"/> Medications for bacterial, viral or fungal infections other than prophylaxis                          |                           |
|  | <input type="radio"/> Ulcer Therapy other than prophylaxis  |                           |
|  | <input type="radio"/> Other   |                           |
| Interventions/Procedures   | <input type="radio"/> Yes   |                           |
|  | <input type="radio"/> No  |                           |
| If yes to Interventions/Procedures, Type of Intervention or Procedure  | <input type="radio"/> Bedside therapeutic procedure (e.g. evacuation of pneumothorax, pleural effusion or monitoring lines) | <input type="radio"/> Yes |
|  |   | <input type="radio"/> No  |
|  | <input type="radio"/> Surgical Intervention   |                           |
|  | <input type="radio"/> Endoscopic Intervention   |                           |
|  | <input type="radio"/> Radiologic  |                           |

|   |                           |
|---|---------------------------|
| Intervention  |                           |
| If yes to Blood Transfusion, Units of RBC's   | <input type="text"/>      |
| ICU Admission of 5 days or more?  | <input type="radio"/> Yes |
|   | <input type="radio"/> No  |
| Management of this complication required the patient's hospital stay to be longer than 4 weeks (if initial transplant surgery admission) or 14 days (if subsequent post transplant admission) total | <input type="radio"/> Yes |
|   | <input type="radio"/> No  |
| Residual Disability/Disease resulting from the complication   | <input type="radio"/> Yes |
|   | <input type="radio"/> No  |
| Re-Listing  | <input type="radio"/> Yes |
|   | <input type="radio"/> No  |
| If Yes to Re-Listing, Date of Re-Listing  | <input type="text"/>      |
| Re-Transplantation  | <input type="radio"/> Yes |
|   | <input type="radio"/> No  |
| Death   | <input type="radio"/> Yes |
|   | <input type="radio"/> No  |