



ChiLDReNLink: PROBE

**Form 25N and 25 Liver Transplant PROBE**

**B: DATA COLLECTED AT TIME OF TRANSPLANT**

B1	Date of liver transplant	____ / ____ / ____			
PELD/MELD Scores at time of transplant					
B2	Calculated:	_____			
B3	Exception:	<input type="checkbox"/> Requested but not received <input type="checkbox"/> Not Done			
B4	Status 1 exception:	<input type="checkbox"/> Not requested		<input type="checkbox"/> Requested	
B5	Weight	_____ _____ <input type="checkbox"/> Not Done	<input type="checkbox"/> kgs <input type="checkbox"/> oz	<input type="checkbox"/> lbs	<input type="checkbox"/> oz
B6	Height or length	_____ _____ <input type="checkbox"/> Not Done	<input type="checkbox"/> cm <input type="checkbox"/> inches	<input type="checkbox"/> feet	<input type="checkbox"/> inches
B7	Head circumference	_____	<input type="checkbox"/> cm	<input type="checkbox"/> inches	<input type="checkbox"/> Not Done
Laboratory evaluations done within the week prior to transplant:					
B	Please note: Total bilirubin should not be less in value than direct bilirubin or conjugated bilirubin.				
B8	Total bilirubin	<input type="checkbox"/> = <input type="checkbox"/> < <input type="checkbox"/> >	_____	<input type="checkbox"/> mg/dl <input type="checkbox"/> µmol/l <input type="checkbox"/> Not Done	
B9	Direct bilirubin	<input type="checkbox"/> = <input type="checkbox"/> < <input type="checkbox"/> >	_____	<input type="checkbox"/> mg/dl <input type="checkbox"/> µmol/l <input type="checkbox"/> Not Done	
B10	Conjugated bilirubin	<input type="checkbox"/> = <input type="checkbox"/> < <input type="checkbox"/> >	_____	<input type="checkbox"/> mg/dl <input type="checkbox"/> µmol/l <input type="checkbox"/> Not Done	
B11	Prothrombin time	<input type="checkbox"/> = <input type="checkbox"/> < <input type="checkbox"/> >	_____	<input type="checkbox"/> sec <input type="checkbox"/> Not Done	

**B: DATA COLLECTED AT TIME OF TRANSPLANT**

B12	INR	<input type="radio"/> = <input type="radio"/> < <input type="radio"/> >	<input type="radio"/> Not Done   
B13	Creatinine	<input type="radio"/> = <input type="radio"/> < <input type="radio"/> >	<input type="radio"/> mg/dl <input type="radio"/> µmol/l <input type="radio"/> Not Done
B14	Albumin	<input type="radio"/> = <input type="radio"/> < <input type="radio"/> >	<input type="radio"/> g/dl <input type="radio"/> g/L <input type="radio"/> Not Done
B15	Glucose	<input type="radio"/> = <input type="radio"/> < <input type="radio"/> >	<input type="radio"/> mg/dl <input type="radio"/> mmol/l <input type="radio"/> Not Done
B16	Platelets	<input type="radio"/> = <input type="radio"/> < <input type="radio"/> >	<input type="radio"/> x10 <sup>3</sup> /mm <sup>3</sup> <input type="radio"/> x10 <sup>9</sup> /L <input type="radio"/> Not Done
B17	Cholesterol	<input type="radio"/> = <input type="radio"/> < <input type="radio"/> >	<input type="radio"/> mg/dl <input type="radio"/> mmol/l <input type="radio"/> Not Done
B18	Growth Failure (more than two standard deviations below normal):	<input type="radio"/> No	<input type="radio"/> Yes
B19	Donor Type	<input type="radio"/> Deceased → <b>Skip B21</b> <input type="radio"/> Living related donor → <b>go to B21</b> <input type="radio"/> Living unrelated donor → <b>go to B21</b>	
B20	If deceased donor, specify:	<input type="radio"/> Whole <input type="radio"/> Split	<input type="radio"/> Reduced
B21	Date of initiation of living donor work-up:	____ / ____ / ____	
B23	Donor Age:	_____	<input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Not Done
B24	Donor Gender:	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Not Done	
B25	Donor Weight	_____ _____ <input type="radio"/> Not Done	<input type="radio"/> kgs <input type="radio"/> lbs <input type="radio"/> oz <input type="radio"/> oz
B26	Donor blood type:	<input type="radio"/> A <input type="radio"/> AB	<input type="radio"/> B <input type="radio"/> O <input type="radio"/> Unknown

**B: DATA COLLECTED AT TIME OF TRANSPLANT**

B27	Complications present or actively treated at time of transplant (check all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Ascites <input type="checkbox"/> Failed hepatopertoenterostomy <input type="checkbox"/> Varices <input type="checkbox"/> Encephalopathy <input type="checkbox"/> Hepatopulmonary syndrome <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> No information given <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Cholangitis <input type="checkbox"/> Coagulopathy <input type="checkbox"/> GI Bleed <input type="checkbox"/> Hepatorenal syndrome
-----	---	--

**C: INVESTIGATOR SIGNATURE**

C1	Investigator Signed?	<input type="radio"/> No → <b>Done</b> <input type="radio"/> Yes
C2	Date investigator signed	____ / ____ / ____