



NIDDK  
Liver Transplantation Database  
**INITIAL EVALUATION FORM**  
**CLINICAL & LABORATORY DATA**  
**(Adult and Pediatric)**

01/30/1991

COMPLETION LOG

Data Collector ID \_\_\_\_\_ - \_\_\_\_\_  
Center Initials

DATE

Data Collection \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Data Entry \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Sysid \_\_\_\_\_

Verification \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Cleaned \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Transfer \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY

SCREENING LOG ID \_\_\_\_\_  
site page line

FORM KEYS

Patient ID \_\_\_\_\_

Date of Evaluation \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

INITIAL EVALUATION - CLINICAL  
NIDDK Liver Transplantation Database

PATIENT ID \_\_\_\_\_ -

This form is to be used for both adult and pediatric initial evaluations; however, the asterisked (\*) sections of the clinical form pertain exclusively to pediatric patients and should be completed when appropriate in addition to the main form.

**PERSONAL DATA:** To Remain at Local LTD Center

1. SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2. NAME \_\_\_\_\_  
First M.I. Last Father's Surname

3. If MARRIED  
NAME OF SPOUSE \_\_\_\_\_

4. PERMANENT ADDRESS  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City State  
\_\_\_\_\_  
Zipcode Country  
Phone # ( ) \_\_\_\_\_

**\*5. Complete for PEDIATRIC PATIENTS**

Provide name(s) of parent(s)/guardian(s) with whom patient resides

_____ First	_____ Last	_____ Relationship
_____ First	_____ Last	_____ Relationship

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SSN CODE (last 4 digits) \_\_\_\_\_

Instructions: To be completed by the attending physician; or by the clinical coordinator based upon review of the patient's medical records and consultation with the attending physician at the end of the initial workup.

I. DEMOGRAPHIC DATA

1. Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

1.1 Is patient a pediatric case (age < 16 years)? Yes\_\_ No\_\_

2. Sex 1. Male\_\_ 2. Female\_\_

3. Race/ethnic background (check one)

1. Caucasian\_\_ 2. Black\_\_ 3. Am. Indian/Eskimo\_\_ 4. Hispanic\_\_ 5. Oriental Pacific\_\_  
6. Mideast. Arab\_\_ 7. Indian Subcont.\_\_ 8. Other \_\_\_\_\_  
specify (30 char)

4. Marital status (check one)

1. Never Married\_\_ 2. Married/Cohabiting\_\_ 3. Separated\_\_ 4. Divorced\_\_  
5. Widowed\_\_

5. Date first seen at transplant center for liver transplant evaluation

OR Date of re-evaluation if patient was 1st evaluated ≥ 1 year ago \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

II. When was patient/patient's family FIRST TOLD patient had liver disease?

\_\_\_\_\_ / \_\_\_\_\_  
MM YY

III. SIGNS, SYMPTOMS AND COMPLICATIONS OF LIVER DISEASE

	EVER			IF YES to EVER check whether		DATE 1st Noted
	Yes	No	Unk	PAST	CURRENT	
1. Ascites	_____	_____	_____	_____	_____	_____ / _____ MM YY

IF CURRENTLY PRESENT  
1.1 TENSE? Yes\_\_ No\_\_

IF EVER YES 1.2 Currently on THERAPY? Yes\_\_ No\_\_

2. Bone disease \_\_\_\_\_ / \_\_\_\_\_  
MM YY

IF YES

2.1 Bone Pain	_____	_____	_____	_____	_____
2.2 Fractures	_____	_____	_____	_____	_____
2.3 Rickets	_____	_____	_____	_____	_____

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	EVER			IF YES to EVER		DATE 1st Noted
	Yes	No	Unk	check whether PAST	CURRENT	
2.4 Avascular necrosis	___	___	___	___	___	___/___/___
3. Cholangitis	___	___	___	___	___	___/___/___
4. Coagulopathy (with bruising)	___	___	___	___	___	___/___/___
5. Edema (peripheral)	___	___	___	___	___	___/___/___
6. Encephalopathy	___	___	___	___	___	___/___/___

IF CURRENTLY PRESENT

6.1 Specify STAGE as coded \_\_\_

1. Lethargy and/or asterixis
2. Confusion and disorientation
3. Stupor or coma, but arousable
4. Deep coma

IF EVER YES 6.2 Currently on THERAPY? Yes\_\_ No\_\_

7. Fatigue	___	___	___	___	___	___/___/___
8. GI Bleeding	___	___	___	___	___	___/___/___
8.1 Variceal	___	___	___	___	___	___/___/___

IF EVER YES

8.1.1 No. of variceal bleeds: 1. 1-4 \_\_ 2.  $\geq$  5 \_\_

8.1.2 Ever endoscopically documented? Yes\_\_ No\_\_

8.1.3 Sclerotherapy given? Yes\_\_ No\_\_

IF YES 8.1.3.1 No. of sessions: 1. 1-4 \_\_ 2.  $\geq$  5 \_\_

8.2 Other type	___	___	___	___	___	___/___/___
9. Jaundice	___	___	___	___	___	___/___/___
10. Pruritis/excoriation	___	___	___	___	___	___/___/___
11. Renal failure (creatinine > 2.0 and/or urine output < 10 ml/kg/24 hrs)	___	___	___	___	___	___/___/___

IF CURRENTLY PRESENT

11.1 Dialysis used? Yes\_\_ No\_\_

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\_\_\_\_\_

11.2 Type(s)  1. Hemodialysis  
 2. Peritoneal

EVER ~~IF YES to EVER~~ DATE  
 check whether PAST CURRENT 1st Noted  
 Yes No Unk

12. Spontaneous bacterial peritonitis

\_\_\_\_\_/\_\_\_\_\_  
 MM YY

IF EVER YES

12.1 No. of documented episodes \_\_\_\_\_

**IV. COEXISTING CONDITIONS**

PAST CURRENT  
 Yes No Unk Yes No Unk

1. Arthritis \_\_\_\_\_  
 2. Cardiac disease \_\_\_\_\_

IF YES, specify

\_\_\_\_\_  
 (30 char) (30 char)

3. Cataracts \_\_\_\_\_  
 4. Diabetes Mellitus (with insulin) \_\_\_\_\_  
 5. Diabetes Mellitus (no insulin) \_\_\_\_\_  
 6. Gallbladder disease \_\_\_\_\_  
 7. Hypertension (on therapy) \_\_\_\_\_  
 8. Inflammatory bowel disease \_\_\_\_\_  
 9. Malabsorption and/or Steatorrhea \_\_\_\_\_  
 10. Malignancy (excluding liver as primary source) \_\_\_\_\_

IF YES, specify

\_\_\_\_\_  
 (30 char) (30 char)

11. Pancreatic disease \_\_\_\_\_

IF YES, specify

\_\_\_\_\_  
 (30 char) (30 char)

12. Peptic ulcer disease \_\_\_\_\_  
 13. Psychiatric condition \_\_\_\_\_

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\_\_\_\_\_

IF YES, specify

_____	_____
(30 char)	(30 char)

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		PAST			CURRENT		
		Yes	No	Unk	Yes	No	Unk
14. Pulmonary disease		___	___	___	___	___	___
	IF YES, specify	_____			_____		
		(30 char)			(30 char)		
15. Renal disease		___	___	___	___	___	___
	IF YES, specify	_____			_____		
		(30 char)			(30 char)		
16. Renal lithiasis		___	___	___	___	___	___
17. Seizures		___	___	___	___	___	___
18. Other neurologic disease		___	___	___	___	___	___
	IF YES, specify	_____			_____		
		(30 char)			(30 char)		
19. Thyroid disease		___	___	___	___	___	___
	IF YES, specify	_____			_____		
		(30 char)			(30 char)		
20. Duodenitis/Esophagitis/Gastritis		___	___	___	___	___	___
21. Psoriasis		___	___	___	___	___	___
22. Raynaud's disease		___	___	___	___	___	___
23. Scleroderma/CREST syndrome		___	___	___	___	___	___
24. Other diseases		___	___	___	___	___	___
	IF YES, specify	_____			_____		
		(30 char)			(30 char)		
25. Other diseases		___	___	___	___	___	___
	IF YES, specify	_____			_____		
		(30 char)			(30 char)		
26. Other diseases		___	___	___	___	___	___
	IF YES, specify	_____			_____		
		(30 char)			(30 char)		
27. Other diseases		___	___	___	___	___	___
	IF YES, specify	_____			_____		

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\_\_\_\_\_

(30 char)

(30 char)

\_\_\_\_\_



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**V. SIGNIFICANT INFECTIONS (clinically documented)**

	PAST			CURRENT		
	Yes	No	Unk	Yes	No	Unk
1. Oral herpes (cold sores)	_____	_____	_____	_____	_____	_____
2. Genital herpes	_____	_____	_____	_____	_____	_____
3. Shingles	_____	_____	_____	_____	_____	_____
4. Mononucleosis	_____	_____	_____	_____	_____	_____
5. CMV	_____	_____	_____	_____	_____	_____
6. Candida (systemic)	_____	_____	_____	_____	_____	_____
7. Other fungal infection (blastomycosis, cryptococcus, coccidioidomycosis, histoplasmosis)	_____	_____	_____	_____	_____	_____
8. Tuberculosis	_____	_____	_____	_____	_____	_____
9. Clinical hepatitis A	_____	_____	_____	_____	_____	_____
10. Clinical hepatitis B	_____	_____	_____	_____	_____	_____
11. Clinical hepatitis B + Delta	_____	_____	_____	_____	_____	_____
12. Clinical hepatitis C	_____	_____	_____	_____	_____	_____
13. Clinical hepatitis, type unknown	_____	_____	_____	_____	_____	_____
14. Pneumonia	_____	_____	_____	_____	_____	_____
15. Urinary tract infections	_____	_____	_____	_____	_____	_____
16. Septicemia	_____	_____	_____	_____	_____	_____
17. Other	_____	_____	_____	_____	_____	_____

IF YES, specify

_____	_____
(30 char)	(30 char)

18. Other

IF YES, specify

_____	_____
(30 char)	(30 char)

19. Other

IF YES, specify

_____	_____
(30 char)	(30 char)

20. Other

IF YES, specify

_____	_____
(30 char)	(30 char)

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VI. IMMUNIZATIONS

1. Was Hepatitis B vaccine ever administered? Yes\_\_ No\_\_ Unk\_\_

IF YES

1.1 No. doses _____
1.2 Year of most recent _____

2. Was pneumovax ever administered? Yes\_\_ No\_\_ Unk\_\_

IF YES

2.1 Date _____ / _____
MM YY

\*3. IMMUNIZATIONS FOR PEDIATRIC PATIENTS ONLY

3.1 Are immunizations current to date? Yes\_\_ No\_\_ Unk\_\_

IF NO, check the immunizations that are not up to date

<input type="checkbox"/> 3.1.1 Diphtheria	<input type="checkbox"/> 3.1.5 Measles
<input type="checkbox"/> 3.1.2 Pertussis	<input type="checkbox"/> 3.1.6 Mumps
<input type="checkbox"/> 3.1.3 Tetanus	<input type="checkbox"/> 3.1.7 Rubella
<input type="checkbox"/> 3.1.4 Polio	<input type="checkbox"/> 3.1.8 Varicella

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VII. HISTORY OF EXPOSURES (medically documented)

1. POTENTIAL HEPATOTOXIC DRUG EXPOSURE Yes\_\_ No\_\_ Unk\_\_

IF YES, check if ever used

<input type="checkbox"/> 1.1 Acetaminophen (greater than recommended dose)
<input type="checkbox"/> 1.2 Androgens
<input type="checkbox"/> 1.3 Antabuse (disulfiram)
<input type="checkbox"/> 1.4 Dilantin
<input type="checkbox"/> 1.5 Estrogens
<input type="checkbox"/> 1.6 Isoniazide (INH)
<input type="checkbox"/> 1.7 Methotrexate
<input type="checkbox"/> 1.8 Methyldopa
<input type="checkbox"/> 1.9 Nitrofurantoin
<input type="checkbox"/> 1.10 Oral contraceptives
<input type="checkbox"/> 1.11 Phenothiazines (Thorazine)
<input type="checkbox"/> 1.12 Phenylbutazone
<input type="checkbox"/> 1.13 Sulfas
<input type="checkbox"/> 1.14 Tegretol
<input type="checkbox"/> 1.15 Valproic Acid
<input type="checkbox"/> 1.16 Other _____
<input type="checkbox"/> 1.17 Other _____
<input type="checkbox"/> 1.18 Other _____
<input type="checkbox"/> 1.19 Other _____
specify (30 char)

2. TOXIN EXPOSURE Yes\_\_ No\_\_ Unk\_\_

IF YES, check all that apply

<input type="checkbox"/> 2.1 Pesticides
<input type="checkbox"/> 2.2 Industrial solvents
<input type="checkbox"/> 2.3 Mushroom toxins
<input type="checkbox"/> 2.4 Other _____
<input type="checkbox"/> 2.5 Other _____
<input type="checkbox"/> 2.6 Other _____

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\_\_\_\_\_

\_\_ 2.7 Other \_\_\_\_\_  
specify (30 char)

\_\_\_\_\_

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3. DRINKING AND SMOKING HISTORY

3.1 Ever drink alcohol? Yes\_\_ No\_\_ Unk\_\_

IF YES

3.1.1	Currently drink?	Yes__	No__	Unk__
IF YES	3.1.1.1 Number of drinks during a typical week _____			
IF NO	3.1.1.2 When did patient stop drinking? ____/____ MM YY			
	3.1.1.3 Previous number of drinks during a typical week _____			
3.1.2	For how many years did the patient drink? _____			
3.1.3	Has patient ever thought or been told that he/she may have a drinking problem? Yes__ No__ Unk__			

3.2 Ever smoke cigarettes? Yes\_\_ No\_\_ Unk\_\_

IF YES

3.2.1	Currently smoke?	Yes__	No__	Unk__
IF YES	3.2.1.1 Average number of packs per week _____			
IF NO	3.2.1.2 When did patient stop smoking? ____/____ MM YY			
	3.2.1.3 Previous average number of packs per week _____			
3.2.2	For how many years did the patient smoke? _____			

4. FAMILY HISTORY OF LIVER DISEASE Yes\_\_ No\_\_ Unk\_\_

IF YES, specify

	Relation to patient	Liver disease
4.1	_____	_____
4.2	_____	_____
4.3	_____	_____
4.4	_____	_____
	(30 char)	(30 char)

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\_\_\_\_\_

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VIII. HISTORY OF PRIOR ABDOMINAL SURGERY Yes\_\_ No\_\_ Unk\_\_  
IF YES

1. BILIARY SURGERY Yes\_\_ No\_\_ Unk\_\_

IF YES, check all that apply

	Date of most recent
<input type="checkbox"/> 1.1 Percutaneous/endoscopic procedure	____/____
<input type="checkbox"/> 1.2 Surgical biliary drainage	____/____
<input type="checkbox"/> 1.3 Cholecystectomy	____/____
<input type="checkbox"/> 1.4 Common bile duct repair/resection	____/____
<input type="checkbox"/> 1.5 Kasai (portoenterostomy)	____/____ MM YY

IF KASAI WAS DONE

Were there revisions?	Yes__ No__
IF YES	No. of revisions: 1. One__ 2. > One__

2. HEPATIC RESECTION Yes\_\_ No\_\_ Unk\_\_

IF YES

2.1 Specify reason (check one)	<input type="checkbox"/> 1. Biliary disease	<input type="checkbox"/> 4. Tumor: malignant
	<input type="checkbox"/> 2. Infection	<input type="checkbox"/> 5. Tumor: benign
	<input type="checkbox"/> 3. Trauma	<input type="checkbox"/> 6. Tumor: polycystic
2.2 Date of most recent	____/____	
	MM YY	

3. OPEN LIVER BIOPSY Yes\_\_ No\_\_ Unk\_\_

IF YES

3.1 Date of most recent	____/____
	MM YY

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4. PORTOSYSTEMIC SHUNTS Yes\_\_ No\_\_ Unk\_\_

IF YES, check type(s)

	Date of most recent
__ 4.1 Portocaval	____/____
__ 4.2 Splenorenal central	____/____
__ 4.3 Splenorenal distal (Warren)	____/____
__ 4.4 Mesocaval	____/____
__ 4.5 Other _____	____/____
__ 4.6 Other _____	____/____
__ 4.7 Other _____	____/____
__ 4.8 Other _____	____/____
specify (30 char)	MM YY

5. PERITONEAL VENOUS SHUNT (Denver, LeVeen) Yes\_\_ No\_\_ Unk\_\_

IF YES

5.1 Date of most recent	____/____	MM	YY
5.2 Were there thrombotic complications?	Yes__	No__	Unk__
5.3 Was shunt removed?	Yes__	No__	Unk__
IF NO	5.3.1 Is it patent? Yes__ No__ Unk__		
IF YES	5.3.2 Date removed ____/____ MM YY		

6. SPLENECTOMY Yes\_\_ No\_\_ Unk\_\_

IF YES

6.1 Date	____/____	MM	YY
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7. OTHER ABDOMINAL SURGERY or nonbiliary percutaneous intervention

Yes\_\_ No\_\_ Unk\_\_

IF YES, check all that apply

	Date of most recent
<input type="checkbox"/> 7.1 Ulcer	____/____
<input type="checkbox"/> 7.2 Esophageal transection	____/____
<input type="checkbox"/> 7.3 Colectomy	____/____
<input type="checkbox"/> 7.4 Small bowel resections	____/____
<input type="checkbox"/> 7.5 Pancreas surgery	____/____
<input type="checkbox"/> 7.6 Appendectomy	____/____
<input type="checkbox"/> 7.7 OB/GYN	____/____
<input type="checkbox"/> 7.8 Other	____/____ MM YY

IX. HISTORY OF BLOOD TRANSFUSIONS

Yes\_\_ No\_\_ Unk\_\_

IF YES

	Past 3 mos.	4-6 mos.	7-12 mos.	More than 12 mos.
Number of transfusion episodes	_____	_____	_____	_____

X. PHYSICAL EXAMINATION

DATE OF EXAM

\_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

1. Height \_\_\_\_\_ cm  ins x 2.54

2. Weight \_\_\_\_\_ kg  lbs ) 2.2

3. Nutritional status (check one)

- 1. Excellent (well nourished)
- 2. Fair (mild/moderate depletion or partially repleted)
- 3. Poor (severe depletion)

4. Muscle wasting Yes\_\_ No\_\_

5. Hepatomegaly Yes\_\_ No\_\_

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\_\_\_\_\_

6. Spleen palpable      Yes\_\_    No\_\_

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\* PHYSICAL EXAMINATION for PEDIATRIC PATIENTS ONLY

7. Estimated dry weight \_\_\_\_\_ kg \_\_\_\_\_ lbs ) 2.2

7.1 Percentile height for age (NCHS chart) \_\_\_\_\_

7.2 Percentile dry weight for age (NCHS chart) \_\_\_\_\_

7.3 Last effective date for best weight percentile: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY

8. Head circumference (for patients  $\leq$  3 years of age) \_\_\_\_\_ cm \_\_\_\_\_ ins x 2.54

8.1 Percentile for age (NCHS chart) \_\_\_\_\_

9. KARNOFSKY SCALE  
(check one)

DATE OF ASSESSMENT

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY

- 1. Normal, no complaints, no evidence of disease. (Does not look or act like he/she has liver disease and, in the case of adults, admittedly feels fine).
- 2. Able to carry on normal activity, minor signs or symptoms of disease. (Works/attends school/plays normally in spite of slight or intermittent evidence of disease, e.g. fatigue).
- 3. Normal activity with effort, some signs or symptoms of disease. (Works/attends school/plays normally but chronically does not feel well, e.g. chronic fatigue, chronic pruritus).
- 4. Cares for self (consistent with age) but unable to carry on normal activity or to do active work/school/play. (Has had to quit usual work duties (in or outside of the home)/can no longer attend school/play is more passive than active at this point).
- 5. Requires occasional assistance (beyond general age appropriate level) but is able to care for most of own needs. (Experiences periods of time when activities of daily living are not possible for him/her to accomplish (appropriate for age). This is the younger child who usually can walk or sit by self but periodically cannot do this independently).
- 6. Requires considerable assistance and frequent medical care. (Can, at best, only assist with activities of daily living appropriate for age. This is the infant who now needs considerable help with feedings that formerly had been easy. Also has need of frequent clinic and/or hospital visits for management of signs/symptoms of end-stage disease (ie., recurrent cholangitis, encephalopathy, chronic unrelieved pruritus, ascites that is difficult to manage)).
- 7. Disabled, requires special care and assistance. (Requires total care of most of his/her needs including specialized needs that might include: hemodialysis, tube feeding, home hyperalimentation, etc.).

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KARNOFSKY SCALE (continued)

- \_\_\_ 8. Severely disabled, hospitalization is indicated although death not imminent. (Is not well enough to be managed safely or completely at home any longer).
- \_\_\_ 9. Hospitalization necessary, very sick, active support treatment necessary. (Constant medical and/or surgical intervention to keep patient alive such as: FFP infusions/exchange transfusions to control coagulopathy, frequent infections requiring one or more antibiotics, treatment of variceal bleeds, may or may not need ventilator assistance but probably requires O<sub>2</sub>).
- \_\_\_ 10. Moribund, fatal processes progressing rapidly. (May include the following: multiple infections, hepatic coma, active bleeding, and labile BP requiring vasopressors).

10. **NUMBER OF DAYS HOSPITALIZED** during the past year for liver disease related problems (exclude childbirth, etc.) \_\_\_\_\_

XI. **CURRENT MEDICATION USE** Yes\_\_\_ No\_\_\_

IF YES, code as specified in Appendix I

	CODE	NAME (30 characters)	Check here if <u>Other</u> med.
1.	___ ___ ___	_____	_____
2.	___ ___ ___	_____	_____
3.	___ ___ ___	_____	_____
4.	___ ___ ___	_____	_____
5.	___ ___ ___	_____	_____
6.	___ ___ ___	_____	_____
7.	___ ___ ___	_____	_____
8.	___ ___ ___	_____	_____
9.	___ ___ ___	_____	_____
10.	___ ___ ___	_____	_____
11.	___ ___ ___	_____	_____
12.	___ ___ ___	_____	_____
13.	___ ___ ___	_____	_____
14.	___ ___ ___	_____	_____
15.	___ ___ ___	_____	_____
16.	___ ___ ___	_____	_____
17.	___ ___ ___	_____	_____

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18. \_\_\_\_\_

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XII. DIAGNOSIS OF LIVER DISEASE

Use code(s) provided in Liver Disease Diagnoses list on opposite page. List in order - primary, secondary, etc., and specify when appropriate.

1. Referral diagnosis (prior to present evaluation)

	Code	Specification (for #5, 9, 12, 17, 19, 20, 27, 28, 32, 35)
1.1	_____	_____
1.2	_____	_____
1.3	_____	_____

specify (30 char)

2. Current diagnosis (diagnosis at completion of present evaluation)

	Code	Specification (for #5, 9, 12, 17, 19, 20, 27, 28, 32, 35)
1.1	_____	_____
1.2	_____	_____
1.3	_____	_____

specify (30 char)



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This page to be completed by Coordinator upon completion of the evaluation of the patient.

XIII. 1. DATE OF MEDICAL ELIGIBILITY as candidate for liver transplantation determined \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

2. STATUS (check one)

\_\_\_ 1. Medically acceptable, look for donor

1.1 Date first activated on list \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

1.2 Contributing reasons for transplantation (must be determined by a physician).  
Check all that apply:

- \_\_\_ 1.2.1 Bone disease
- \_\_\_ 1.2.2 Encephalopathy
- \_\_\_ 1.2.3 Poor quality of life secondary to fatigue
- \_\_\_ 1.2.4 Pruritis
- \_\_\_ 1.2.5 Recurrent GI bleeding
- \_\_\_ 1.2.6 SBP
- \_\_\_ 1.2.7 Tumor
- \_\_\_ 1.2.8 Uncontrolled ascites
- \_\_\_ 1.2.9 Malnutrition/failure to thrive/failed Kasai procedure
- \_\_\_ 1.2.10 Renal failure
- \_\_\_ 1.2.11 Coagulopathy
- \_\_\_ 1.2.12 Recurrent cholangitis/sepsis/abscess
- \_\_\_ 1.2.13 Other \_\_\_\_\_  
specify (30 char)

1.3 Specify by code the major reason for transplantation from the above list \_\_\_\_\_

1.4 Code UNOS STATUS as listed on the opposite page \_\_\_\_\_

\_\_\_ 2. Suitable, but too well

\_\_\_ 3. Contraindications

3.1 Check all that apply: 1. Medical\_\_\_ 2. Financial\_\_\_ 3. Personal\_\_\_

3.2 Possibly reversible? Yes\_\_\_ No\_\_\_

IF NO reason \_\_\_\_\_  
specify (30 char)

**INITIAL EVALUATION - CLINICAL**  
NIDDK Liver Transplantation Database

PATIENT ID \_\_\_\_\_ -

\_\_\_\_\_

\_\_\_\_\_

INITIAL EVALUATION - CLINICAL  
NIDDK Liver Transplantation Database

PATIENT ID \_\_\_\_\_ -

XIV. LABORATORY DATA

**INSTRUCTIONS:** To be completed by the clinical coordinator at the time of the Initial Evaluation of the patient. Results recorded should be the first set of results obtained at the Center; if not done at Center, values sent by the referring physician may be used. Tests preceded by "\*" are one-time tests; results may be obtained from 1) previous medical records; 2) the referring physician; or 3) tests done at the clinical center.

1. HEMATOLOGY

Not Done  
(-2)

- 1.1 Hemoglobin (HGB) \_\_\_\_\_g/dl \_\_\_\_\_
- 1.2 Hematocrit (HCT) \_\_\_\_\_% \_\_\_\_\_
- 1.3 Platelet count x 10<sup>3</sup> \_\_\_\_\_, \_\_\_\_\_cells/mm<sup>3</sup> \_\_\_\_\_
- 1.4 White blood cells (WBC) x 10<sup>3</sup> \_\_\_\_\_cells/mm<sup>3</sup> \_\_\_\_\_
- 1.5 Prothrombin time (PT) \_\_\_\_\_/\_\_\_\_\_.secs.  
Patient Control \_\_\_\_\_
- 1.6 Partial thromboplastin time (PTT) \_\_\_\_\_/\_\_\_\_\_.secs.  
Patient Control \_\_\_\_\_

Did patient receive exchange transfusion within 48 hours of date of sample? Yes\_\_ No\_\_

\*\* 1.7 Serum iron \_\_\_\_\_ug/dl \_\_\_\_\_

OR

\*\* 1.8 Serum ferritin \_\_\_\_\_ng/ml \_\_\_\_\_

\*\* 1.9 Red cell typing

1.9.1 Blood type (check one) 1. A\_\_ 2. B\_\_ 3. AB\_\_ 4. O\_\_

1.9.2 Rh factor (check one) +\_\_ --\_\_

2. CLINICAL CHEMISTRY

- 2.1 Alkaline phosphatase \_\_\_\_\_U/L \_\_\_\_\_
- 2.2 Total bilirubin \_\_\_\_\_mg/dl \_\_\_\_\_
- 2.3 Direct bilirubin \_\_\_\_\_mg/dl \_\_\_\_\_
- 2.4 SGOT (AST) \_\_\_\_\_U/L \_\_\_\_\_
- 2.5 SGPT (ALT) \_\_\_\_\_U/L \_\_\_\_\_
- 2.6 Gamma GTP \_\_\_\_\_U/L \_\_\_\_\_
- 2.7 Albumin \_\_\_\_\_g/dl \_\_\_\_\_
- 2.8 Alpha feto-protein \_\_\_\_\_ng/ml \_\_\_\_\_

INITIAL EVALUATION - CLINICAL  
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PATIENT ID \_\_\_\_\_-

2.9 Bicarbonate	___ ___ mEq/L	___	
			Not Done (-2)
2.10 Blood urea nitrogen	___ ___ mg/dl	___	
2.11 Calcium	___ ___ mg/dl	___	
** 2.12 Ceruloplasmin	___ ___ mg/dl	___	
2.13 Chloride	___ ___ mEq/L	___	
2.14 Cholesterol	___ ___ mg/dl	___	
2.15 Creatinine	___ ___ mg/dl	___	
2.16 Glucose	___ ___ mg/dl	___	
2.17 Potassium	___ ___ mEq/L	___	
2.18 Sodium	___ ___ mEq/L	___	
2.19 Total protein	___ ___ g/dl	___	

3. URINE STUDIES

3.1 Creatinine clearance                    \_\_\_ \_\_\_ ml/min

Number of hours                    \_\_\_\_\_

OR 3.2 GFR (glomerular filtration rate)                    \_\_\_ \_\_\_ ml/min

\*\* 4. IMMUNOLOGY

4.1 Antinuclear antibody (ANA)                    Pos \_\_\_    Neg \_\_\_                    \_\_\_

4.2 Anti-smooth muscle antibody (ASMA)                    Pos \_\_\_    Neg \_\_\_                    \_\_\_

4.3 Anti-mitochondrial antibody (AMA)                    Pos \_\_\_    Neg \_\_\_                    \_\_\_

4.4 Alpha-1-antitrypsin phenotype                    \_\_\_ \_\_\_                    \_\_\_

5. GASES - In room air (if possible)                    1. Arterial \_\_\_                    2. Venous \_\_\_                    \_\_\_

5.1 FiO <sub>2</sub>	___ ___	___
5.2 Hemoglobin O <sub>2</sub> saturation	___ ___ %	___
5.3 pO <sub>2</sub>	___ ___ mm Hg	___
5.4 pCO <sub>2</sub>	___ ___ mm Hg	___
5.5 pH	___ ___	___
5.6 Base excess/deficit	___ ___ mEq/L	___

**INITIAL EVALUATION - CLINICAL**  
NIDDK Liver Transplantation Database

PATIENT ID \_\_\_\_\_ -

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5.7 Active bicarbonate

\_\_ \_\_ mEq/L

\_\_\_\_\_

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INITIAL EVALUATION - CLINICAL  
 NIDDK Liver Transplantation Database

PATIENT ID \_\_\_\_\_-

6. INFECTION SCREEN

<u>Viral serologies</u>	<u>RESULTS</u>		Date of Blood Sample	Not Done (-2)
	Pos	Neg		
6.1 Anti-CMV IgG	___	___	___/___/___ MM DD YY	___

IF POS 

Titer	_____
-------	-------

6.2 Anti-CMV IgM	___	___	___/___/___	___
6.3 Anti-EBV (VCA) IgG	___	___	___/___/___	___
6.4 Anti-EBV (VCA) IgM	___	___	___/___/___	___
6.5 Anti-HSV	___	___	___/___/___	___
6.6 Anti-HAV	___	___	___/___/___	___
6.7 Anti-HAV IgM	___	___	___/___/___	___
6.8 HBsAg	___	___	___/___/___	___
6.9 Anti-HBc	___	___	___/___/___	___

IF HBsAg POSITIVE

6.10 Anti-HBc IgM	___	___	___/___/___	___
6.11 HBeAg	___	___	___/___/___	___
6.12 Anti-HBe	___	___	___/___/___	___
6.13 Anti-HDV	___	___	___/___/___	___

6.14 Anti-HBs	___	___	___/___/___	___
6.15 Anti-HCV	___	___	___/___/___	___
** 6.16 Anti-HIV	___	___	___/___/___	___

IF HIV POSITIVE

** 6.17 Western Blot	___	___	___/___/___	___
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** 6.18 Anti-HTLV1	___	___	___/___/___	___
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