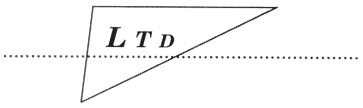
CP



NIDDK

Liver Transplantation Database

IMMEDIATE PRE-OPERATIVE FORM

CLINICAL & LABORATORY DATA

01/30/1991

DONOR ID _____

COMPLETION LOG

Data Collector ID _____-_____
Center Initials

DATE

Data Collection ____/_____/_____

Data Entry _____/_____/_____

Sysid _____

Verification _____/_____/_____

Cleaned _____/_____/_____

Transfer _____/_____/_____
MM DD YY

FORM KEYS

Patient ID _____

Transplant No. _____

CP

IMMEDIATE PRE-OPERATIVE - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _____-_____

TRANSPLANT NO. _____

DATE TAKEN TO SURGERY _____/_____/_____
MM DD YY

INSTRUCTIONS: To be completed for each transplant. In the case of first transplant complete all items. In the case of retransplant, complete only items preceded by "--- >".

I. MEDICAL STATUS

---> 1. Was PHYSICAL EXAM performed prior to surgery? Yes__ No__ Unk__

IF YES

1.1 Height _____cm _____ins x 2.54

1.2 Weight _____kg _____lbs) 2.2

1.3 Nutritional status (check one)

__ 1. Excellent (well nourished)

__ 2. Fair (mild/moderate depletion or partially repleted)

__ 3. Poor (severe depletion)

1.4 Muscle wasting Yes__ No__

2. SIGNS, SYMPTOMS AND COMPLICATIONS OF LIVER DISEASE

	SINCE INITIAL EVALUATION (or most recent transplant)			CURRENTLY PRESENT (within 48 hrs)		
	Yes	No	Unk	Yes	No	Unk
---> 2.1 Ascites	____	____	____	____	____	____

IF CURRENTLY PRESENT

2.1.1 TENSE? Yes__ No__

2.2 Bone disease - fractures	____	____	____	____	____	____

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		SINCE INITIAL EVALUATION (or most recent transplant)			CURRENTLY PRESENT (within 48 hrs)		
		Yes	No	Unk	Yes	No	Unk
--->	2.3 Edema (peripheral)	____	____	____	____	____	____

IF CURRENTLY PRESENT

2.3.1 Diuretic therapy given?
Yes__ No__

	2.4 Encephalopathy	____	____	____	____	____	____

IF YES

2.4.1 Enter code for the worst STAGE____ ____

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

	2.5 GI bleeding						
	2.5.1 Variceal	____	____	____	____	____	____
	2.5.2 Other type	____	____	____	____	____	____
	2.6 Infection: cholangitis	____	____	____	____	____	____

IF YES

2.6.1 Code organism (given on opposite page) _____ _____

	2.7 Infection: bacteremia	____	____	____	____	____	____

IF YES

2.7.1 Code organism (given on opposite page) _____ _____

	2.8 Infection: spontaneous bacterial peritonitis	____	____	____	____	____	____

IF YES

2.8.1 Code organism (given on opposite page) _____ _____

IMMEDIATE PRE-OPERATIVE - CLINICAL
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	SINCE INITIAL EVALUATION (or most recent transplant)			CURRENTLY PRESENT (within 48 hrs)		
	Yes	No	Unk	Yes	No	Unk
2.9 Infection(s): other	____	____	____	____	____	____

IF YES, code as specified on opposite page

	Site	Organism	Site	Organism
1.	____	____	____	____
2.	____	____	____	____
3.	____	____	____	____
4.	____	____	____	____

2.10 Renal failure (creatinine > 2.0 and/or urine output < 10 ml/kg/24 hrs) ____ ____ ____ ____ ____ ____

2.11 Coagulopathy (e.g. easy bruising) ____ ____ ____ ____ ____ ____

IF YES, specify _____ _____
(30 char) (30 char)

2.12 ARDS/Lung complications ____ ____ ____ ____ ____ ____

IF YES, specify _____ _____
(30 char) (30 char)

2.13 Other ____ ____ ____ ____ ____ ____

IF YES, specify

1. _____	1.	_____
2. _____	2.	_____
3. _____	3.	_____
4. _____	4.	

CP

IMMEDIATE PRE-OPERATIVE - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _____-
_____

_____
(30 char) (30 char)

IMMEDIATE PRE-OPERATIVE - CLINICAL
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PATIENT ID _____-_____

---> 3. Major THERAPY modality since the initial evaluation (or since most recent transplant)

Yes__ No__ Unk__

IF YES, check all that apply

__ 3.1 Dialysis
__ 3.2 Sclerotherapy IF YES 3.2.1 Number of sessions _____
__ 3.3 Surgery _____
specify (30 char)
__ 3.4 Transfusion(s) IF YES 3.4.1 Whole blood and/or PRBC used _____units
__ 3.5 Paracentesis IF YES 3.5.1 Number of sessions _____
__ 3.6 Percutaneous portal caval shunt
__ 3.7 Other _____
__ 3.8 Other _____
__ 3.9 Other _____
specify (30 char)

---> 4. IMMUNIZATIONS

4.1 Has Hepatitis B vaccine been administered since initial evaluation (or since most recent transplant)?

Yes__ No__ Unk__

IF YES
4.1.1 No. doses ____
4.1.2 Date of most recent _____/_____/_____
MM DD YY

4.2 Has pneumovax been administered since initial evaluation (or since most recent transplant)?

Yes__ No__ Unk__

IF YES
4.2.1 Date _____/_____/_____
MM DD YY

---> 5. Was patient admitted for transplantation prior to this time and the surgery was cancelled? Yes__ No__

IMMEDIATE PRE-OPERATIVE - CLINICAL
NIDDK Liver Transplantation Database

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---> II. 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.).

__ 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_2).

__10. Moribund, fatal processes progressing rapidly. (May include the following: multiple infections, hepatic coma, active bleeding, and labile BP requiring vasopressors).

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_____

---> III. CURRENT MEDICATIONS: at time of surgery (including pre-op meds and maintenance meds.)

Yes__ No__

IF YES, code as specified in Appendix I

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

IMMEDIATE PRE-OPERATIVE - CLINICAL
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PATIENT ID _____-
_____

---> III. CURRENT MEDICATIONS (continued)

	CODE	NAME (30 characters)	Check here if Other med.
18.	____ ____ ____	_____	____
19.	____ ____ ____	_____	____
20.	____ ____ ____	_____	____
21.	____ ____ ____	_____	____
22.	____ ____ ____	_____	____
23.	____ ____ ____	_____	____
24.	____ ____ ____	_____	____
25.	____ ____ ____	_____	____
26.	____ ____ ____	_____	____
27.	____ ____ ____	_____	____
28.	____ ____ ____	_____	____
29.	____ ____ ____	_____	____
30.	____ ____ ____	_____	____
31.	____ ____ ____	_____	____
32.	____ ____ ____	_____	____
33.	____ ____ ____	_____	____
34.	____ ____ ____	_____	____
35.	____ ____ ____	_____	____

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IV. 1. Was there a CHANGE IN DIAGNOSIS OF LIVER DISEASE since the Initial Evaluation?

Yes__ No__

IF YES

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

	Code	Specification (for #5, 9, 12, 17, 19, 20, 27, 28, 32, 35)
1.1	_____	_____
1.2	_____	_____
1.3	_____	_____ specify (30 char)

---> 2. UNOS STATUS (code as listed below) _____

1. At home and functioning normally.
2. Continuous medical care.
3. Continuously hospitalized.
4. ICU. Acute and chronic liver failure.

V. LABORATORY DATA

INSTRUCTIONS: To be completed by the clinical coordinator using the LTD center's laboratory reports for tests done closest to the time of transplantation within 30 days. Do not include tests done at Initial Evaluation.

---> 1. HEMATOLOGY Date of sample _____/_____/_____ MM DD YY Not Done (-2)

1.1 Hemoglobin (HGB)	___ ___.___g/dl	____
1.2 Hematocrit (HCT)	___ ___.___%	____
1.3 Platelet count x 10^3	___,___ ___ ___cells/mm^3	____
1.4 White blood cells (WBC) x 10^3	___ ___.___cells/mm^3	____
1.5 Prothrombin time (PT)	__ __.__/__ __.__secs. Patient Control	____
1.6 Partial thromboplastin time (PTT)	__ __ __.__/__ __ __.__secs. Patient Control	____

1.7 Did patient receive exchange transfusion within 48 hours of date of sample? Yes__ No__

IMMEDIATE PRE-OPERATIVE - CLINICAL
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---> 2. CLINICAL CHEMISTRY Date of sample _____/_____/_____ (-2) Not Done
MM DD YY

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	____
2.9	Bicarbonate	__ __ __mEq/L	____
2.10	Blood urea nitrogen	__ __ __.___mg/dl	____
2.11	Calcium	__ __.___mg/dl	____
2.12	Chloride	__ __ __mEq/L	____
2.13	Cholesterol	__ __ __ __mg/dl	____
2.14	Creatinine	__ __.__mg/dl	____
2.15	Glucose	__ __ __mg/dl	____
2.16	Potassium	__.__mEq/L	____
2.17	Sodium	__ __ __mEq/L	____
2.18	Total protein	__ __.__g/dl	____

3. INFECTION SCREEN

		RESULTS Pos	RESULTS Neg	Date of Blood Sample (MM DD YY)	Not Done (-2)
	Viral serologies				
3.1	Anti-CMV IgG	____	____	_____/_____/_____	____
	Titer _____				
3.2	Anti-CMV IgM	____	____	_____/_____/_____	____
3.3	Anti-EBV (VCA) IgG	____	____	_____/_____/_____	____
3.4	Anti-EBV (VCA) IgM	____	____	_____/_____/_____	____
3.5	Anti-HSV	____	____	_____/_____/_____	____
3.6	Anti-HAV	____	____	_____/_____/_____	____
3.7	Anti-HAV IgM	____	____	_____/_____/_____	____

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INFECTION SCREEN (continued)

Viral serologies	RESULTS Pos	Neg	Date of Blood Sample (MM DD YY)	Not Done (-2)
3.8 HBsAg	____	____	_____/_____/_____	____
3.9 Anti-HBc	____	____	_____/_____/_____	____
IF HBsAg POSITIVE				
3.10 Anti-HBc IgM	____	____	_____/_____/_____	____
3.11 HBeAg	____	____	_____/_____/_____	____
3.12 Anti-HBe	____	____	_____/_____/_____	____
3.13 Anti-HDV	____	____	_____/_____/_____	____
3.14 Anti-HBs	____	____	_____/_____/_____	____
3.15 Anti-HCV	____	____	_____/_____/_____	____

---> 4. CULTURES (within 48 hours)

	RESULTS Pos	Neg	Not Done (-2)
4.1. BLOOD			
4.1.1 CMV	____	____	____
4.1.2 Bacteria	____	____	____

IF POSITIVE, code as specified on opposite page

1. ____ 2. ____ 3. ____ 4. ____ 5.____

4.1.3 Candida	____	____	____
4.1.4 Aspergillus	____	____	____
4.1.5 Other	____	____	____

_____
specify (30 char)

4.2. URINE			
4.2.1 CMV	____	____	____
4.2.2 Bacteria	____	____	____

IF POSITIVE, code as specified on opposite page

1. ____ 2. ____ 3. ____ 4. ____ 5.____

4.2.3 Candida	____	____	____
4.2.4 Aspergillus	____	____	____
4.2.5 Other	____	____	____

_____
specify (30 char)

IMMEDIATE PRE-OPERATIVE - CLINICAL
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4.3.OTHER SOURCES: Yes__ No__

IF YES, code as specified on opposite page

	Site	Microorganism
4.3.1	_____	_____
4.3.2	_____	_____
4.3.3	_____	_____
4.3.4	_____	_____
4.3.5	_____	_____

5.HISTOCOMPATIBILITY TESTING Date of Sample _____/_____/_____
MM DD YY

These 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.

Record results as given: code -3 for blanks, -2 for not tested.

5.1 HLA-A _____/_____
5.2 HLA-B _____/_____
5.3 HLA-DR _____/_____

** The following are optional; record if done

5.4 HLA-BW4/6 _____/_____
5.5 HLA-C _____/_____
5.6 HLA-DRW52/53 _____/_____
5.7 HLA-DQ _____/_____
5.8 HLA-DP _____/_____

---> 6. CROSSMATCH RESULTS Date of most recent serum _____/_____/_____
MM DD YY

6.1 T cell crossmatch Pos ___ Neg___

6.2 Method used _____
specify (30 char)

---> 7.Was the patient on a ventilator within the past 48 hours? Yes ___ No ___

IMMEDIATE PRE-OPERATIVE - CLINICAL
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_____

---> VI. COMMENTS: Yes__ No__

IF YES

_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
(60 char/line)