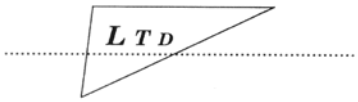
EP



NIDDK

Liver Transplantation Database

END OF STUDY ASSESSMENT (PEDIATRIC)

05/26/1995

COMPLETION LOG

Data Collector ID _____-_____
Center Initials

DATE

Data Collection _____/_____/_____

Data Entry _____/_____/_____

Sysid _____

Verification _____/_____/_____

Cleaned _____/_____/_____

Transfer _____/_____/_____
MM DD YY

FORM KEYS

Patient ID _____-_____

THIS FORM WAS FILLED OUT BY (check one)

____ the patient without assistance
____ the patient with assistance from LTD coordinator in person
____ the LTD coordinator in phone interview with patient
____ the patient with assistance from a family member
Relationship _____
____ a family member
Relationship _____

EP

END OF STUDY ASSESSMENT (PEDIATRIC)

INTRODUCTION

The data collection phase of the study of liver transplantation in which you or your child has been a participant is scheduled to end in July of 1995. At this time, we would like to obtain a final assessment of liver transplant candidates and recipients enrolled in the study. We ask that you fill out this final form and return it to us in the enclosed envelope. All information will remain confidential. Thank you for your participation in this study.

Name of patient: _____ _____ _____
(First) (Initial) (Last)

1. What is today's date? _____/_____/_____
MM DD YY

2. Has the patient received a liver transplant since July 1, 1994? (check one)

__ No. Please move on to question 3.1.

__ Yes. Please provide the following information for all liver transplants since July 1, 1994, and then move on to question 3.2.

	Date of Transplant (Month / Day / Year)	MEDICAL CENTER (Check one for each transplant) Mayo	UNMC (Nebraska)	UCSF (San Francisco)	Other
2.1	_____ / ____/ _____	_____	_____	_____	_____
2.2	_____ / ____/ _____	_____	_____	_____	_____
2.3	_____ / ____/ _____	_____	_____	_____	_____

3.1 How much does the patient weigh now (without shoes)?

_____ pounds

3.2 How tall is the patient now (without shoes)?

_____ inches

END OF STUDY ASSESSMENT (PEDIATRIC)

4. Is the patient currently being treated for high blood pressure? (check one)

__ No

__ Yes

Please list the medications that the patient is taking for high blood pressure:

4.1 _____

4.2 _____

4.3 _____

4.4 _____

5. Has a physician told you that the patient has diabetes? (check one)

__ No

__ Yes

What treatment is the patient receiving for diabetes? (check all that apply)

__ 5.1 Insulin injection

__ 5.2 Oral medication (pills). Please list the medication names under #7.

__ 5.3 Diet

__ 5.4 None

6. What immunosuppressive medications is the patient currently taking? (check all that apply)

__ 6.1 Cyclosporine (Sandimmune)

__ 6.2 FK506 (Prograf)

__ 6.3 Azathioprine (Imuran)

__ 6.4 Prednisone (Meticorten, Orasone, Deltasone)

__ 6.5 Prednisolone (Prednisolone sodium phosphate)

__ 6.6 Methylprednisolone (Medrol, Meprolone, Solu-medrol)

__ 6.7 RS61443 (Mycophenolate mofetil)

__ 6.8 Other (specify) _____

7. List all other medications the patient is taking that are not previously mentioned:

END OF STUDY ASSESSMENT (PEDIATRIC)

7.1 _____

7.2 _____

7.3 _____

7.4 _____

7.5 _____

7.6 _____

7.7 _____

7.8 _____

8. May we contact you in the future for additional information and follow-up on the patient's status?

__ No

__ Yes

PLEASE SIGN

Signature _____

THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE.