 L T D	
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# NIDDK

# Liver Transplantation Database

# END OF STUDY ASSESSMENT (ADULTS)

05/26/1995

	COMPLETION LOG	
	Data Collector ID	-
		Center Initials
		DATE
	Data Collection	/
	Data Entry	/
	Sysid	
FORM KEYS	Verification	/
Patient ID	Cleaned	/
	Transfer	/ / MM DD YY
THIS FORM WAS FILLED OUT BY (check one)		
the patient without assistance		
the patient with assistance from LTD coordinator	r in person	
the LTD coordinator in phone interview with patie	ent	
the patient with assistance from a family membe	er	
Relationship		_
a family member		
Relationship		

#### INTRODUCTION

The data collection phase of the study of liver transplantation in which you have 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.

Na	me of pation	ent: (First)	(Initial)	(Last)		
1.	What is t	oday's date?////	/ <sub>YY</sub>			
2.	Have you	ı received a liver transplant	since July 1	<u>, 1994</u> ? (chec	k one)	
	No.	Please move on to quest	ion 3.			
	Yes.	Please provide the follow and then move on to que		on for all liver	transplants <u>since</u>	<u>July 1, 1994,</u>
					CAL CENTER r each transplant)	
	(	Date of Transplant Month / Day / Year)	Mayo	UNMC (Nebraska)	UCSF (San Francisco)	Other
	2.1	//				
	2.2	//				
	2.3	//				
3.	How muc	ch do you weigh without she	oes?			

4. Since your transplant, have you had (or still have) any of the following medical problems? (check all that apply)

			Had	St	ill have
	4.1	Arthritis			
	4.2	Gout			
	4.3	Headaches			
	4.4	Back pain			
	4.5	Bone fractures			
	4.6	Kidney dialysis			
	4.7	Stroke			
	4.8	Myocardial infarction (heart attack)			
	4.9	High cholesterol			
	4.10	Overweight			
	4.11	Depression			
	4.12	Ulcerative colitis (inflammatory bowel disease)			
	4.13	Skin cancer			
	4.14	Other cancers including lymphoma,			
		specify			
5.	N		k one)		
	Y				
		ise list the medications you are taking for high blood press	ure:		
		5.1			
		5.2			
		5.3			
	5	5.4			

6.	Has a phy	sician told you that you have diabetes? (check one)
	No	
	Yes	
	What to	reatment are you receiving for diabetes? (check all that apply)
	6.1	Insulin injection
	6.2	Oral medication (pills). Please list the medication names under #8.
	6.3	Diet
	6.4	None
7.	What imm	unosuppressive medications are you currently taking? (check all that apply)
	_ 7.1 (	Cyclosporine (Sandimmune)
	_ 7.2 F	FK506 (Prograf)
	_ 7.3 /	Azathioprine (Imuran)
	_ 7.4 F	Prednisone (Meticorten, Orasone, Deltasone)
	_ 7.5 F	Prednisolone (Prednisolone sodium phosphate)
	_ 7.6 N	Methylprednisolone (Medrol, Meprolone, Solu-medrol)
	_ 7.7 F	RS61443 (Mycophenolate mofetil)
	_ 7.8 (	Other (specify)
8.	List all oth	er medications you are taking that are not previously mentioned:
	8.1	<u> </u>
	8.2 _	
	8.3 _	
	8.4	
	8.5	
	8.6	
	8.7	
	8.8	
	8.9	
	8.10 _	
	8.11 _	
	8.12	

9.	Are you currently receiving disability benefits from the Social Security Administration? (check one)
	No
	Yes
10.	Are you receiving benefits from any other source due to a disability? (check one)
	No
	Yes
11.	How would you rate your overall quality of life at this time? (check one)
	1. Excellent
	2. Good
	3. Fair
	4. Poor
12.	May we contact you in the future for additional information and follow-up on your status?
	No
	_ Yes
	PLEASE SIGN
	Signature

# THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE.