



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. \_\_\_\_\_

**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   
1.2 Weight \_\_\_\_\_ kg   
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

2.2 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 <u>worst</u> 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) _____
--

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SINCE INITIAL EVALUATION (or most recent transplant)  
Yes No Unk  
CURRENTLY PRESENT (within 48 hrs)  
Yes No Unk

2.9 Infection(s): other \_\_\_\_\_

IF YES, code as specified on opposite page

Site	Organism	Site	Organism
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	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.

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ID

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(30 char)

(30 char)

\_\_\_\_\_

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

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

IF YES, check all that apply

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

<input type="text"/> 4.1.1 No. doses _____
<input type="text"/> 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

<input type="text"/> 4.2.1 Date _____ / _____ / _____ MM DD YY
---

---> 5. Was patient admitted for transplantation prior to this time and the surgery was cancelled? Yes\_\_ No\_\_

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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<sub>2</sub>).
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 <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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---> **III. CURRENT MEDICATIONS (continued)**

	CODE	NAME (30 characters)	Check here if <u>Other</u> 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 \_\_\_\_/\_\_\_\_/\_\_\_\_      Not Done (-2)

MM   DD   YY

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	

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

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---> 2. CLINICAL CHEMISTRY

Date of sample \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

Not Done  
(-2)

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 fetoprotein	____ _ 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

<u>RESULTS</u>		Date of	Not Done
Pos	Neg	Blood Sample	(-2)

Viral serologies

3.1 Anti-CMV IgG	____	____	____/____/____	____
Titer	_____		MM DD YY	
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) <u>Viral serologies</u>	<u>RESULTS</u>		Date of Blood Sample	Not Done (-2)
	Pos	Neg		
3.8 HBsAg	___	___	___/___/___ MM DD YY	___
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)

	<u>RESULTS</u>		Not Done (-2)
	Pos	Neg	
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)			

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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 \_\_\_

