LD

NIDDK

Liver Transplantation Database

LIVING DONOR FORM

05/10/1993

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. _____

LD

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PATIENT ID _____-_____

TRANSPLANT NO. _____

I. DEMOGRAPHIC DATA

1. Birthdate _____/_____/_____
MM DD YY

2. Sex 1. Male__ 2. Female__

3. Height _____ cm | _____ Inches x 2.54

4. Weight _____ kg | _____ lbs) 2.2

5. Blood type (check one) 1. A__ 2. B__ 3. AB__ 4. 0__
6. Rh factor (check one) Pos__ Neg__
7. 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_____ 9. Unk__
specify (30 char)

8. Relation to recipient (check one)

1. Mother__ 2. Father__ 3. Sibling__
4. Other _____
specify (30 char)

II. PRE-EXISTING/CO-EXISTING CONDITIONS

	Yes	No
1. History of alcohol use	____	____

IF YES

1.1 Years of use _____
1.2 Number of drinks per week _____
1.3 Date of most recent use _____/_____/_____
MM DD YY

	Yes	No
2. History of drug use	____	____

IF YES

2.1 Years of use _____
2.2 Date of most recent use _____/_____/_____
MM DD YY

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	Yes	No
3. Hypertension	____	____
4. Seizure disorder (treated)	____	____
5. Diabetes mellitus	____	____
6. Pulmonary disease	____	____
7. Renal disease	____	____
8. Hepatitis (history of clinical)	____	____

_____
specify type (30 char)

9. Infections (current) ____ ____

IF YES

	Site	Organism
9.1	_____	_____
9.2	_____	_____
9.3	_____	_____
9.4	_____	_____
	specify (30 char)	specify (30 char)

III. ANTIBIOTICS GIVEN? (Pre-op only) Yes__ No__

IF YES, code as specified in Appendix I

	CODE	NAME (30 characters)
1.	____ ____ ____	_____
2.	____ ____ ____	_____
3.	____ ____ ____	_____
4.	____ ____ ____	_____
5.	____ ____ ____	_____
6.	____ ____ ____	_____
7.	____ ____ ____	_____
8.	____ ____ ____	_____
9.	____ ____ ____	_____
10.	____ ____ ____	_____

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IV. LABORATORY DATA AT TIME OF SELECTION AS DONOR Date of Sample _____/_____/_____
MM DD YY

			Not Done (-2)
1.	Total bilirubin	___ ___.__ mg/dl	_____
2.	Direct bilirubin	___ ___.__ mg/dl	_____
3.	SGOT (AST)	__ __ __ __ __ U/L	_____
4.	SGPT (ALT)	__ __ __ __ __ U/L	_____
5.	BUN	___ ___ ___.__ mg/dl	_____
6.	Creatinine	___ ___.__ mg/dl	_____
7.	Prothrombin time (PT)	__ __.__/__ __.__ secs Patient Control	_____

V. INFECTIOUS DISEASE SCREEN Date of Sample _____/_____/_____
MM DD YY

		RESULTS Pos	RESULTS Neg	Not Done (-2)
1.	Anti-CMV IgG	____	____	____
	IF POSITIVE 1.1 Titer _____			____
2.	HBsAg	____	____	____
3.	Anti-HBs	____	____	____
4.	Anti-HBc	____	____	____
5.	Anti-HCV	____	____	____
6.	Anti-HIV	____	____	____
7.	Anti-HTLV1	____	____	____
8.	Routine Blood Culture			
	8.1 Bacteria	____	____	____
	IF POSITIVE 8.1.1 _____ specify (30 char)			
	8.2 Other _____ specify (30 char)	____	____	____
	8.3 Other _____ specify (30 char)	____	____	____

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VI. HISTOCOMPATIBILITY TESTING (#4-#8 are optional, record if done) Date of Sample _____/_____/_____ MM DD YY

1. HLA-A _____/_____
2. HLA-B _____/_____
3. HLA-DR _____/_____
4. HLA-BW4/6 _____/_____
5. HLA-C _____/_____
6. HLA-DRW52/53 _____/_____
7. HLA-DQ _____/_____
8. HLA-DP _____/_____

VII. PRE-OPERATIVE MORPHOLOGY ASSESSMENT

1. Liver scan performed? Yes__ No__
2. Normal parenchyma (CT or MRI) Yes__ No__
3. Segments to be removed (check one)

___ 3.1 Segments 2 and 3
___ 3.2 Segments 2, 3, and 4
___ 3.3 Other _____
specify (30 char)

4. Pre-operative graft volume _____ cc
5. Pre-operative graft weight _____ kg
6. Arteriogram performed? Yes__ No__

IF YES, check one

Arterial anatomy
___ 6.1 Normal variant
___ 6.2 Replaced left (from left gastric)
___ 6.3 Multiple left
___ 6.4 Other variant _____
specify (30 char)

7. Replaced right hepatic Yes__ No__

VIII. DONOR RECOVERY

	Date	Local LTD Center time
1. Partial Hepatectomy Start Time	_____/_____/_____	____ : ____
2. Partial Hepatectomy Flush Time	_____/_____/_____	____ : ____
3. Partial Hepatectomy End Time	_____/_____/_____	____ : ____
	MM DD YY	hrs min

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4. Arterial dissection (check all that apply)

___ 4.1 Full left _____ mm
___ 4.2 Replaced left _____ mm
___ 4.3 Other _____ mm

_____
specify (30 char)

5. Graft used (check one)

___ 5.1 Segments 2 and 3
___ 5.2 Segments 2, 3, and 4
___ 5.3 Other _____
specify (30 char)

6. Portal Vein

6.1 Length _____ mm
6.2 Diameter _____ mm

7. Hepatic Vein (check one)

___ 7.1 Single
___ 7.2 Multiple

8. Bile duct cholangiogram performed? Yes__ No__

IF YES, check one

___ 8.1 Full left Diameter _____ mm
___ 8.2 Common channel Diameter _____ mm
___ 8.3 Separate ducts 2 and 3

8.3.1 Segment 2 Diameter _____ mm
8.3.2 Segment 3 Diameter _____ mm

9. Graft volume (displacement) _____ cc

10. Donor veins retrieved (check all that apply)

___ 10.1 Saphenous Diameter _____ mm Length _____ mm
___ 10.2 Inferior vena cava Diameter _____ mm
___ 10.3 Other _____ Diameter _____ mm
specify (30 char)

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IX. FLUSH

1. TYPES (check all that apply)

	1. PORTAL VEIN	2. ARTERY	3. PRESERVATION SOLUTION	4. TOTAL VOLUME (CC)
1.1 UW	_____	_____	_____	_____
1.2 LR	_____	_____	_____	_____
1.3 OTAR	_____	_____	_____	_____
1.4 Other	_____	_____	_____	_____

_____
specify (30 char)

2. Were medications added to flush? Yes__ No__
IF YES, check all that apply

	PORTAL VEIN	ARTERY
2.1 Calciparine	_____	_____
2.2 D50	_____	_____
2.3 Heparin	_____	_____
2.4 Mannitol	_____	_____
2.5 Solumedrol	_____	_____
2.6 Insulin	_____	_____
2.7 Penicillin	_____	_____
2.8 Other _____ specify (30 char)	_____	_____
2.9 Other _____ specify (30 char)	_____	_____

X. INTRA-OPERATIVE

1. Were there intraoperative complications? Yes__ No__
IF YES, check all that apply

___ 1.1 Excessive bleeding
___ 1.2 Damage to structure of Donor
IF YES, check all that apply

___ 1.2.1 Bile duct
___ 1.2.2 Hepatic artery
___ 1.2.3 Damage to other organ
specify _____
(30 char)

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2. Was there blood loss? Yes__ No__ IF YES 2.1 Volume _____ cc

3. Was replacement blood given? Yes__ No__

IF YES, check all that apply

___ 3.1 Autologous	_____ cc
___ 3.2 Cell saver	_____ cc
___ 3.3 Banked RBC's	_____ cc

XI. ANTIBIOTICS USED DURING SURGERY Yes__ No__

IF YES, code as specified in Appendix I

	CODE	NAME (30 characters)
1.	____ ____ ____	_____
2.	____ ____ ____	_____
3.	____ ____ ____	_____
4.	____ ____ ____	_____
5.	____ ____ ____	_____
6.	____ ____ ____	_____
7.	____ ____ ____	_____
8.	____ ____ ____	_____
9.	____ ____ ____	_____
10.	____ ____ ____	_____

XII. ASSESSMENT OF LIVER

	START (At time of incision)		END (At time of crossclamp or flush)	
	Yes	No	Yes	No
1.1 Consistency/Texture: normal	___	___	___	___
1.2 Perfusion/color: well perfused	___	___	___	___
1.3 Injury/Trauma	___	___	___	___

2. How did the liver flush? (check one) 1. Good__ 2. Fair__ 3. Poor__

3. Overall quality of liver (check one) 1. Good__ 2. Fair__ 3. Poor__

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XIII. IMPLANTATION: GRAFT ASSESSMENT IN RECIPIENT

1. Hepatic Vein (check one)

___ 1.1 End to end RHV Diameter _____ mm
___ 1.2 End to end LHV Diameter _____ mm
___ 1.3 End to side IVC Diameter _____ mm
___ 1.4 End to Right, Middle & Left Vein Diameter _____ mm

2. Portal Vein (check one)

___ 2.1 End to end Diameter _____ mm Length _____ mm
___ 2.2 Interposition Diameter _____ mm Length _____ mm

3. Hepatic artery (check one)

___ 3.1 Recipient HA Diameter _____ mm
___ 3.2 Aorta Diameter _____ mm

4. Bile duct

4.1 Roux Y Yes__ No__
4.2 Number of ducts_____

XIV. SURGEON ID

_____-_____
Center # (2 char) Initials (3 char)

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XV. COMMENTS: Yes__ No__

IF YES

(60 char/line)