ChiLDReNLink: PROBE

PROBE Form 25N and 25 Liver Transplant

B: DATA COLLECTED AT TIME OF TRANSPLANT		
B1	Date of liver transplant	___ ___ / ___ ___ / ___ ___ ___ ___
PELD/MELD Scores at time of transplant		
B2	Calculated:	_____
B3	Exception:	O Requested but not received _____ O Not Done
B4	Status 1 exception:	O Not requested O Requested
B5	Weight	_____ O kgs O lbs O oz _____ O oz O Not Done
B6	Height or length	_____ O cm O feet O inches _____ O inches O Not Done
B7	Head circumference	_____ O cm O inches O Not Done
Laboratory evaluations done within the week prior to transplant:		
B	Please note: Total bilirubin should not be less in value than direct bilirubin or conjugated bilirubin.	
B8	Total bilirubin	O = O mg/dl O < O µmol/l O > O Not Done _____
B9	Direct bilirubin	O = O mg/dl O < O µmol/l O > O Not Done _____
B10	Conjugated bilirubin	O = O mg/dl O < O µmol/l O > O Not Done _____
B11	Prothrombin time	O = O sec O < O Not Done O > _____

B: DATA COLLECTED AT TIME OF TRANSPLANT			
B12	INR	O = O < O > _____	O Not Done
B13	Creatinine	O = O < O > _____	O mg/dl O µmol/l O Not Done
B14	Albumin	O = O < O > _____	O g/dl O g/L O Not Done
B15	Glucose	O = O < O > _____	O mg/dl O mmol/l O Not Done
B16	Platelets	O = O < O > _____	O x10^3/mm^3 O x10^9/L O Not Done
B17	Cholesterol	O = O < O > _____	O mg/dl O mmol/l O Not Done
B18	Growth Failure (more than two standard deviations below normal):	O No	O Yes
B19	Donor Type	O Deceased → **Skip B21** O Living related donor → **go to B21** O Living unrelated donor → **go to B21**	
B20	If deceased donor, specify:	O Whole O Split	O Reduced
B21	Date of initiation of living donor work-up:	___ ___ / ___ ___ / ___ ___ ___ ___	
B23	Donor Age:	_____	O Years O Months O Not Done
B24	Donor Gender:	O Male	O Female O Not Done
B25	Donor Weight	_____ O kgs O lbs O oz _____ O oz O Not Done	
B26	Donor blood type:	O A O B O O O AB O Unknown	

B: DATA COLLECTED AT TIME OF TRANSPLANT		
B27	Complications present or actively treated at time of transplant (check all that apply):	□ None □ Ascites □ Failed hepatoportoenterostomy □ Varices □ Encephalopathy □ Hepatopulmonary syndrome □ Other, specify: _____ □ No information given □ Failure to thrive □ Cholangitis □ Coagulopathy □ GI Bleed □ Hepatorenal syndrome

C: INVESTIGATOR SIGNATURE		
C1	Investigator Signed?	O No → **Done** O Yes _____
C2	Date investigator signed	___ ___ / ___ ___ / ___ ___ ___ ___