

MALAYSIAN HEART AND LUNG TRANSPLANT NOTIFICATION FORM

Instruction: Complete this form to notify all transplant patients in your centre to National Transplant Registry. Where check boxes are provided, check **one box** as appropriate unless specified otherwise. NA refers to Not Applicable. Fill in the date with dd/mm/yy format.

Office use:		
Centre:		

*Name of reporting centre: _____ *Date (dd/mm/yy):

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SECTION 1 : PROVIDER INFORMATION

*1. _____ <small>Provider Number Transplant Center Name</small>	*2. _____ <small>Provider Number Follow-up Hospital Name:</small>		
3. Chart #: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 40px; height: 20px;"></td></tr></table>		4. 9IS #: (UNOS use only) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 40px; height: 20px;"></td></tr></table>	

SECTION 2 : RECIPIENT INFORMATION

*1. Name of Patient: _____	*2. RN: _____
*3. Identification Card Number :	Old IC: _____ New IC: _____ Other ID document no: _____ Specify type (eg. passport, armed force ID): _____ <12 years: Birth cert #: _____ I/C Guardian: Mother / Father Sibling ranking: _____
4. Date of Birth (dd/mm/yy): _____	5. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Ethnic group:	<input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Bumiputra Sarawak <input type="checkbox"/> Bumiputra Sabah <input type="checkbox"/> Others, specify: _____
7. Religion:	<input type="checkbox"/> Islam <input type="checkbox"/> Buddhism <input type="checkbox"/> Christianity <input type="checkbox"/> Hinduism <input type="checkbox"/> Others, specify: _____ <input type="checkbox"/> Unknown
8. Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown
9. Education Level:	<input type="checkbox"/> Uneducated <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Others, specify: _____ <input type="checkbox"/> Unknown
10. Date added to wait list (dd/mm/yy): _____	*11. Date of transplant (dd/mm/yy): _____
12. State of residence: _____	
13. Country of residence: <input type="checkbox"/> Malaysia <input type="checkbox"/> Others, specify: _____	
14. Immediate Pretransplant employment status: (Select one)	
<input type="checkbox"/> Student <input type="checkbox"/> Working Part Time, Reason Unknown <input type="checkbox"/> Not Working, Reason Unknown <input type="checkbox"/> Working Full Time <input type="checkbox"/> Not Working By Choice <input type="checkbox"/> Retired <input type="checkbox"/> Working Part Time By Choice <input type="checkbox"/> Not Working Due to Disease <input type="checkbox"/> Employment Status Unknown <input type="checkbox"/> Working Part Time Due to Disease <input type="checkbox"/> Not Working, Unable to Find Employment <input type="checkbox"/> Others, specify: _____	

SECTION 3 : IMMEDIATE PRETRANSPLANT CLINICAL INFORMATION

1. ABO Blood Group <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O	
2. Weight (kg): _____	
3. Height (cm): _____	
4a. Heart diagnosis: (Use code)	<input type="checkbox"/> Ischaemic Cardiomyopathy <input type="checkbox"/> End Stage Valvular heart disease <input type="checkbox"/> Idiopathy Dilated Cardiomyopathy <input type="checkbox"/> Hypertrophic Cardiomyopathy <input type="checkbox"/> Restrictive Cardiomyopathy <input type="checkbox"/> Other, Specify : _____
4b. Lung diagnosis/specify: _____	
5a. Medical condition: (Select one)	5b. Patient on Life support (Check applicable)
<input type="checkbox"/> Patient in Intensive Care Unit <input type="checkbox"/> Hospitalized, but not in Intensive Care Unit <input type="checkbox"/> Not hospitalized	<input type="checkbox"/> ECMO Duration: _____ hrs <input type="checkbox"/> IABP Duration: _____ hrs <input type="checkbox"/> PGE Duration: _____ days <input type="checkbox"/> IV Inotropes Duration: _____ days <input type="checkbox"/> Nasal Ventilation Duration: _____ days <input type="checkbox"/> Noninvasive Ventilation, CPAP Duration: _____ days <input type="checkbox"/> Noninvasive Ventilation, BiPAP Duration: _____ days <input type="checkbox"/> Long Term Oxygen Therapy Duration: _____ days <input type="checkbox"/> Other mechanism Specify: _____
<input type="checkbox"/> LVAD* <input type="checkbox"/> HeartMate IP <input type="checkbox"/> HeartMate VE <input type="checkbox"/> HeartMate II <input type="checkbox"/> Novacor PC <input type="checkbox"/> Novacor PCq <input type="checkbox"/> Thoratec <input type="checkbox"/> Arrow Lionheart <input type="checkbox"/> HeartSaver VAD <input type="checkbox"/> Micromed DeBakey <input type="checkbox"/> Jarvik 2000 <input type="checkbox"/> Pittsburgh AB180 <input type="checkbox"/> Berlin Heart <input type="checkbox"/> Medos <input type="checkbox"/> Toyobo <input type="checkbox"/> Type unspecified	
<input type="checkbox"/> RVAD* <input type="checkbox"/> Thoratec <input type="checkbox"/> Berlin Heart <input type="checkbox"/> Medos <input type="checkbox"/> Abiomed BVS <input type="checkbox"/> Toyobo <input type="checkbox"/> BioMedicus <input type="checkbox"/> Type unspecified	
<input type="checkbox"/> TAH* <input type="checkbox"/> Cardiowest <input type="checkbox"/> AbioCor <input type="checkbox"/> Type unspecified	
5c. Date of implantation (dd/mm/yy): _____	

**SECTION 3 : IMMEDIATE PRETRANSPLANT
CLINICAL INFORMATION (continue)**

6. Functional Status: (How does the patient perform activities of daily living? Select one)

- No activity limitations. (NYHA Class I or Class II)
- Performs activities of daily living with some assistance. (NYHA Class III)
- Performs activities of daily living with total assistance. (NYHA Class IV)
- N/A Patient hospitalized
- Unknown

7. Pretransplant Serology

		Negative	Positive	Unknown
a. HIV		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. CMV	IgG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	DNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Hep B	Core Antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Surface Antigen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HBV DNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hep C	Antibody Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	RIBA Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HCV RNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. EBV	IgG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	DNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

f. Most recent Hemodynamics

		Inotropes/Vasodilators		
PA (sys) actual:	_____ mm/Hg	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> U
PA (dia) estimate:	_____ mm/H	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> U
PA (mean):	_____ mm/H	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> U
PCW (mean):	_____ mm/H	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> U
CO:	_____ L/min	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> U
Ejection Fraction:	_____ %	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> U

8.

- a. Most recent Serum Creatinine: _____ μmol/L
- b. Most recent Serum Total Bilirubin: _____ μmol/L
- c. Oxygen requirement at rest: _____ L/min
- d. Chronic Steroid Use: N Y U
- e. FEV1(L)/FVC(L): _____ / _____
- f. pO₂ on room air: _____ on oxygen: _____

9. Pulmonary Status

- a. FVC: _____ % Predicted
- b. FEV1: _____ % Predicted
- c. pCO₂: _____ mmHg

10. General Medical Factors

a. Diabetes

- No Diabetes
- Insulin Dependent Diabetes
- Non-Insulin Dependent Diabetes
- Diabetes, Dependency Unknown
- Unknown

b. Dialysis

- No Dialysis
- Hemodialysis
- Peritoneal Dialysis
- Unknown

c. Peptic Ulcer Disease

- No
- Yes, Drug Treated
- Yes, Not Drug Treated
- Yes, Drug Treatment Unknown
- Unknown

**d. Unstable Angina /
Coronary Artery Disease /
Myocardial Infarction**

- No
- Stable CAD
- Unstable CAD
- Old MI
- Unknown

10. General Medical Factors (continue)

- e. Drug Treated Systemic Hypertension N Y U
- f. Symptomatic Cerebrovascular Disease N Y U
- g. Symptomatic Peripheral Vascular Disease N Y U
- h. Drug Treated COPD N Y U
- i. Pulmonary Embolism (within last 6 months) N Y U
- j. Any Previous Transfusions N Y U
- k. Any Previous Malignancy (Exclude non-melanoma skin cancer) N Y U
- l. PRA N Y
- m. Any cigarette use within last 6 months N Y U

11. Heart Medical Factors

- a. Sudden Death N Y U
- b. Antiarrhythmics N Y U
- c. Amiodarone N Y U
- d. Implantable defibrillator N Y U
- e. Cardiac Resynchronisation Therapy N Y U
- f. Exercise oxygen consumption: _____ ml/min/kg

12. Events Occurring to Listing for Transplant

- a. Pneumothorax N Y U
- b. Infection requiring IV drug therapy (within two weeks prior to listing) N Y U
- c. Left ventricular remodeling N Y U
- d. Pneumoreduction N Y U
- e. Transmyocardial revascularization (TMR) N Y U
- f. Sternotomy None 1 +1 U
- g. CABG N Y U
- h. Thoracotomy: Left N Y U
- i. Thoracotomy: Right N Y U
- j. Pleurodesis N Y U

13. Lung Medical Factors

- a. IV Treated Pulmonary Sepsis Episodes > 2 in last 12 months N Y U
- b. Corticosteroid Dependency > 5 mg/day N Y U
- c. Six minute walk distance < 150 ft. N Y U
- d. Pan-Resistant Bacterial Infection N Y U

14. HLA Typing:

- a. Method: Serology DNA Other, specify: _____

b. Typing:

A:	B:	DR:
A:	B:	DR:

SECTION 4 : TRANSPLANT CLINICAL INFORMATION

1. Multiple Organ Recipient: Y N
 check all organs that apply
 Liver Kidney Intestine
 Pancreas Pancreas Islets Bone Marrow

2a. Procedure Type: (Check applicable)
 Ortho Heart Single Right Lung
 Hetero Heart Bilateral Sequential Lung
 Heart Lung En-Bloc Double Lung
 Single Left Lung Others: _____

2b. Procedure Information (Heart only):
 Orthotopic Bicaval
 Orthotopic Traditional
 Heterotopic

3. Total Organ Ischaemic Time:
 Heart _____ min
 Heart - Lung _____ min
 Left Lung _____ min
 Right Lung _____ min

SECTION 5 : POST TRANSPLANT CLINICAL INFORMATION

1. Events Prior to Discharge:

a. Any Drug Treated Rejection Y N U
 b. Any Drug Treated Infection Y N U
 c. Stroke Y N U
 d. Dialysis Y N U
 e. Re-Operation, Hemorrhage Y N U
 f. Re-Operation, Other Y N U
 g. Other Surgical Procedures Y N U
 h. Prolonged Graft Dysfunction Y N U
 i. Permanent Pacemaker Y N U
 j. Bronchopleural Fistula Y N U
 k. Airway Dehiscence Y N U

SECTION 6 : PATIENT STATUS AT DISCHARGE

1. Patient Status
 a. Date of Report or Death (dd/mm/yy): _____
 b. Status:
 Living
 Dead Cause of Death: (Use code) _____
 Specify: _____
 Re-transplanted prior to hospital discharge
 Cause: Hyperacute Rejection Other
 Acute Rejection
 Lost

2. Transplant Hospitalization
 a. Date of discharge from transplant center (dd/mm/yy): _____
 b. Date of admission to transplant center (dd/mm/yy): _____
 c. Was patient transferred from another hospital prior to transplant?
 No Yes Unknown
 Date of admission to transferring hospital (dd/mm/yy): _____

3. Previous Transplants
 (If Yes, give the number of previous transplants for each organ type and latest transplant date.) Yes No

	No.	Date		No.	Date
Kidney			Heart		
Liver			Lung		
Pancreas (whole)			Intestine		
Pancreas (islet cells)			Bone Marrow		

SECTION 7 : TREATMENT AT DISCHARGE

1. Immunosuppressive Information
 Did the patient participate in any clinical research protocol for immunosuppressive medications?
 Yes No
 If Yes, specify: _____

2. Other Therapy
 a. Photopheresis Yes No
 b. Plasmapheresis Yes No
 c. Total Lymphoid Irradiation (TLI) Yes No

3. Antivirals
 a. CMV Globulin Yes No
 b. Acyclovir (Zovirax) Yes No
 c. Ganciclovir (Cytovene) Yes No
 d. Other: _____

SECTION 8 : DONOR INFORMATION

1. Name: _____
2. Age: _____
3. Gender: Male Female
4. Ethnic group: Malay Chinese Indian Bumi Sabah
 Bumi Sarawak Others: _____
5. Country: Malaysia Others*
6. Donor Type: Cadaveric Living
7. Date of Organ Procurement (dd/mm/yy): _____
8. ABO Blood Group A B AB O
9. a) Weight (kg): _____ **b) Height (cm):** _____
10. Cause of Death (Select one)
 Anoxia/Cardiac Arrest Cerebrovascular/Stroke
 Head Trauma CNS Tumor
 Other, specify: _____
11. Mechanism of Death* (Select one)
 Drowning Electrical Intercranial Hemorrhage / Stroke
 Seizure Gunshot Wound Death from Natural Causes
 Drug Intoxication Stab MVA
 Asphyxiation Blunt Injury Cardiovascular Sudden Infant death None of the Above
12. Serology
 a. Anti-HIV I P N U
 b. Anti-HIV II P N U
 c. Anti-HTVL I P N U
 d. Anti-HTVL II P N U
 e. RPR-VDRL P N U
 f. Anti-CMV P N U
 g. HBsAg P N U
 h. Anti-HBC P N U
 i. Anti-HCV P N U
 j. EBV P N U
13. HLA Typing
 a. Method Serology DNA Other, specify: _____
 b. Typing
 A: _____ B: _____ DR: _____
 A: _____ B: _____ DR: _____
14. History Of:
 Hypertension Y N U
 Diabetes Y N U
 Cancer Y N U
 Infection at time of Procurement Y N U
 Donor Coronary Disease Y N U

SECTION 9 : IMMUNOSUPPRESSION THERAPY

	Induct	Days	Maint	Anti-rej
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1. STEROIDS

- | | | | | |
|-----------------------|--------------------------|-------|--------------------------|--------------------------|
| a. Prednisone | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Methylprednisolone | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

2. T-CELL ACTIVATION INHIBITORS

- | | | | | |
|--|--------------------------|-------|--------------------------|--------------------------|
| a. Cyclosporin A (CSA, Sandimmune, CyA, CyS) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Neoral (CyA-NOF) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. FK506 (Prograf, Tacrolimus) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Rapamycin (RAPA, Sirolimus, Rapamune) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Gengraf | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

3. ANTIMETABOLITES

- | | | | | |
|---|--------------------------|-------|--------------------------|--------------------------|
| a. Azathioprine (AZA, Imuran) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Mycophenolate Mofetil (MMF, Cellcept, RS61443) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cytoxan (Cyclophosphamide) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

4. ANTI-LYMPHOCYTE RECEPTOR ANTIBODIES

- | | | | | |
|---|--------------------------|-------|--------------------------|--------------------------|
| a. T10B9 (Medimmune) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. ATG (Atgam, Anti-thymocyte Globulin) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. NRATG / NRATS | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. OKT3 (Orthoclone, Muromonab) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Thymoglobulin | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Zenepax | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Simulect | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

5. CYTOKINE INHIBITORS

- | | | | | |
|-------------------------------|--------------------------|-------|--------------------------|--------------------------|
| a. IL - 1 Receptor Antagonist | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Anti - IL - 6 | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anti - TNF | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Soluble IL - 1 Receptor | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

6. SUPPRESSOR INDUCERS

- | | | | | |
|-------------------------|--------------------------|-------|--------------------------|--------------------------|
| a. Aldesleukin (IL - 2) | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
|-------------------------|--------------------------|-------|--------------------------|--------------------------|

7. OTHER IMMUNOSUPPRESSIVE MEDICATION

- | | | | | |
|--------------|--------------------------|-------|--------------------------|--------------------------|
| Other: _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |