

# CTS COLLABORATIVE TRANSPLANT STUDY

## HEART / LUNG TRANSPLANT

### Basic Follow up

Transplant Center \_\_\_\_\_

Recipient Name (Last, First) \_\_\_\_\_

Transplant Date (Day/Month/Year) \_\_\_\_\_

#### Clinical Outcome Grades

Post Tx	Grade	Post Tx	Grade
3 Months		10 Years	
6 Months		11 Years	
1 Year		12 Years	
2 Years		13 Years	
3 Years		14 Years	
4 Years		15 Years	
5 Years		16 Years	
6 Years		17 Years	
7 Years		18 Years	
8 Years		19 Years	
9 Years		20 Years	

#### Graft Failure Date

\_\_\_\_\_  
(Day/Month/Year)

#### Patient Last Seen

\_\_\_\_\_  
(Day/Month/Year)

#### Death Date

\_\_\_\_\_  
(Day/Month/Year)

#### Cause of Death

- Infection
- Sepsis
- Cardiac / Cardiovascular
- Myocardial Infarction
- Cerebrovascular Accident
- Cancer
- Multi Organ Failure
- Graft Failure
- Other \_\_\_\_\_  
Please specify

#### Legend of Grades:

- E = excellent graft function
- S = satisfactory graft function
- P = poor graft function
  
- F = graft failure for unclear reason, infection, etc.
- I = graft failure due to immunological rejection
- T = technical failure
- N = nonimmunological failure (e.g. suicide, accident)
- C = chronic rejection, accelerated graft atherosclerosis
- O = chronic obliterative bronchiolitis

#### Malignant Tumors

	1. Diagnosis	2. Diagnosis	3. Diagnosis
<b>Diagnosis Date</b> (dd/mm/yy)	-----	-----	-----
<b>Diagnosis Text</b>	-----	-----	-----
<b>ICD-10 Code</b>	-----	-----	-----
<b>If Skin (C44)</b> Type	BCC <input type="checkbox"/> SQCC <input type="checkbox"/>	BCC <input type="checkbox"/> SQCC <input type="checkbox"/>	BCC <input type="checkbox"/> SQCC <input type="checkbox"/>
Other (specify)	-----	-----	-----
<b>If Kaposi</b> Type	Skin only <input type="checkbox"/> Visceral <input type="checkbox"/>	Skin only <input type="checkbox"/> Visceral <input type="checkbox"/>	Skin only <input type="checkbox"/> Visceral <input type="checkbox"/>
<b>If Lymphoma</b> Localization	-----	-----	-----
Type	B-Cell <input type="checkbox"/> T-Cell <input type="checkbox"/>	B-Cell <input type="checkbox"/> T-Cell <input type="checkbox"/>	B-Cell <input type="checkbox"/> T-Cell <input type="checkbox"/>
<b>If Leukemia</b> Lymphoid	Acute <input type="checkbox"/> Chronic <input type="checkbox"/>	Acute <input type="checkbox"/> Chronic <input type="checkbox"/>	Acute <input type="checkbox"/> Chronic <input type="checkbox"/>
Myeloid	Acute <input type="checkbox"/> Chronic <input type="checkbox"/>	Acute <input type="checkbox"/> Chronic <input type="checkbox"/>	Acute <input type="checkbox"/> Chronic <input type="checkbox"/>
Other (specify)	-----	-----	-----

Date \_\_\_\_\_

Signature \_\_\_\_\_

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