

CTS COLLABORATIVE TRANSPLANT STUDY

KIDNEY 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:

- A = excellent graft function, minimal immunosuppression (Serum Creatinine < 130 micromol/l)
 B = good graft function (Serum Creatinine 130 - 259 micromol/l)
 C = mediocre graft function (Serum Creatinine 260 - 400 micromol/l)
 D = poor graft function, but no chronic dialysis (Serum Creatinine > 400 micromol/l)
 F = graft failure for unclear reason, perhaps rejection component, infection, etc.
 I = graft failure due to immunological rejection
 T = technical failure
 N = nonimmunological failure, patient died with a well functioning graft
 O = original disease recurring in transplanted kidney

Malignant Tumors

	1. Diagnosis	2. Diagnosis	3. Diagnosis
Diagnosis Date (dd/mm/yy)	-----	-----	-----
Diagnosis Text	-----	-----	-----
ICD-10 Code	-----	-----	-----
If Skin (C44) 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)	-----	-----	-----
If Kaposi 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"/>
If Lymphoma 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"/>
If Leukemia 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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