

# CTS COLLABORATIVE TRANSPLANT STUDY

## PANCREAS 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, insulin independent, normoglycemic
  - P = partial graft function, clinically relevant reduction of insulin requirement
  
  - F = graft failure for unclear reason, infection
  - I = graft failure due to immunological rejection
  - T = technical failure
  - N = nonimmunological failure

#### 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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