

# CTS COLLABORATIVE TRANSPLANT STUDY

## Immunosuppressive Follow up        **Years** after Transplantation

Transplant Center _____	Recipient Name (Last, First) _____	Transplant Date (Day/Month/Year) _____
Renal function <b>stable</b> ( $\Delta$ % creatinine $\leq$ 20 %) during the last 2 months <input type="checkbox"/> no <input type="checkbox"/> yes		
Renal function <b>unstable for any reason</b> during the last 2 months <input type="checkbox"/> no <input type="checkbox"/> yes		
<b>Current Serum Creatinine:</b> <input type="checkbox"/> < 1.5 mg% (< 130 $\mu$ mol/L)	<b>Current Blood Pressure:</b> Systolic _____ mm Hg	
<input type="checkbox"/> 1.5 - 3.0 mg% (130 - 260 $\mu$ mol/L)	Diastolic _____ mm Hg	
<input type="checkbox"/> 3.0 - 4.5 mg% (260 - 400 $\mu$ mol/L)	Is patient on antihypertensive drugs (excl diuretics)? <input type="checkbox"/> no <input type="checkbox"/> yes	
<input type="checkbox"/> > 4.5 mg% (> 400 $\mu$ mol/L)	Does patient receive ACE inhibitor or ARBs? <input type="checkbox"/> no <input type="checkbox"/> yes	

**Was patient treated for rejection during the last year?**  no  yes

**If yes: How many** rejections were treated?  1  2  3  >3

Date **first rejection** diagnosed or date rejection treatment started: \_\_\_\_\_

Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Rejection treatment with: ATG?  no  yes

Manufacturer \_\_\_\_\_

Monoclonal Antibodies?  no  yes

Type, Manufacturer \_\_\_\_\_

<b>Current immunosuppressive therapy</b>						
	no	yes	Dose/day	Trough Level		
Cyclosporine-Neoral	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL	Evidence for bronchiolitis obliterans: <input type="checkbox"/> no <input type="checkbox"/> yes	
or Cyclosporine generic	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL	Evidence for transplant coronary artery disease: <input type="checkbox"/> no <input type="checkbox"/> yes	
Tacrolimus/FK506	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL	If yes: <input type="checkbox"/> mild	
Sirolimus/Rapamycin	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL	<input type="checkbox"/> moderate	
Everolimus/Certican	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL	<input type="checkbox"/> severe	
MMF Cell Cept	<input type="checkbox"/>	<input type="checkbox"/>	_____ g	_____ ng/mL	} If taken off MMF during last year: _____	
or MMF generic	<input type="checkbox"/>	<input type="checkbox"/>	_____ g	_____ ng/mL		Reason _____
Myfortic	<input type="checkbox"/>	<input type="checkbox"/>	_____ g	_____ ng/mL	→ If taken off Myfortic during last year: _____	
Azathioprine	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg		Reason _____	
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	Prednisone <input type="checkbox"/>	Prednisolone <input type="checkbox"/>	Methylprednisolone <input type="checkbox"/>	Deflazacort <input type="checkbox"/>
Dosage of steroid:	_____ mg/day		or alternating	_____ mg/day on first day	_____ mg/day on second day	
Patient is on Ketoconazole	<input type="checkbox"/> no	<input type="checkbox"/> yes				
Patient is on Diltiazem	<input type="checkbox"/> no	<input type="checkbox"/> yes	Other immunosuppressive drugs currently administered: _____			

<b>Current weight of the patient:</b> _____ kg	<b>Current Serum Cholesterol</b>	<b>Total:</b> <input type="checkbox"/> < 200 mg/dL (< 5.0 mmol/L)
<b>Height of the patient:</b> _____ cm (if < 19 years)		<input type="checkbox"/> 200 - 250 mg/dL (5.0 - 6.5 mmol/L)
		<input type="checkbox"/> 250 - 300 mg/dL (6.5 - 8.0 mmol/L)
		<input type="checkbox"/> > 300 mg/dL (> 8.0 mmol/L)
Is this patient <b>currently a smoker?</b> <input type="checkbox"/> no <input type="checkbox"/> yes		<b>HDL:</b> _____ mg/dL or _____ mmol/L
Is this patient <b>currently treated for diabetes?</b> <input type="checkbox"/> no <input type="checkbox"/> yes		<b>LDL:</b> _____ mg/dL or _____ mmol/L
Is patient on <b>"Statin"</b> treatment? <input type="checkbox"/> no <input type="checkbox"/> yes		

<p>Has this patient been <b>hospitalized because of infection</b> during the last year? <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>If yes: <input type="checkbox"/> bacterial _____ specify bacterium</p> <p><input type="checkbox"/> fungal _____</p> <p><input type="checkbox"/> viral <input type="checkbox"/> CMV <input type="checkbox"/> Herpes <input type="checkbox"/> Other _____ specify virus</p>	<p>Does this patient <b>currently</b> show evidence of:</p> <p><b>Osteonecrosis</b> <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p><b>Osteoporosis</b> <input type="checkbox"/> no <input type="checkbox"/> yes If yes: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe</p> <p>Hip Fracture (ever) <input type="checkbox"/> no If yes: Year _____</p> <p>Other type of <b>bone pain</b> <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p><b>Cataract</b> <input type="checkbox"/> no <input type="checkbox"/> yes</p>
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Date \_\_\_\_\_ Signature \_\_\_\_\_

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