

CTS COLLABORATIVE TRANSPLANT STUDY

Immunosuppressive Follow up Years after Transplantation

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

Monoclonal Antibodies? no yes

Manufacturer

Type, Manufacturer

Current immunosuppressive therapy

	no	yes	Dosage	Trough Level	
Cyclosporine	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg/day	_____ ng/mL	Optoral/Neoral <input type="checkbox"/> Generic <input type="checkbox"/>
Tacrolimus	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg/day	_____ ng/mL	Prograf <input type="checkbox"/> Advagraf <input type="checkbox"/> Generic <input type="checkbox"/>
Mycophenolate (MPA)	<input type="checkbox"/>	<input type="checkbox"/>	_____ g/day	_____ μ g/mL	CellCept <input type="checkbox"/> Myfortic <input type="checkbox"/> Generic <input type="checkbox"/>
Sirolimus/Rapamycin	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg/day	_____ ng/mL	If taken off MPA during last year: _____ Reason
Everolimus/Certican	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg/day	_____ ng/mL	If switched from one MPA to another MPA during last year: _____ Reason
Azathioprine	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg/day		
Belatacept/Nulojix	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg/4weeks	If taken off Nulojix during last year: _____ Reason	
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg/day	Prednisone <input type="checkbox"/> Prednisolone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Deflazacort <input type="checkbox"/>	
			or alternating _____ mg Steroids on first day		
			_____ mg Steroids on second day		
Other immunosuppressive drugs currently administered:	_____				Evidence for bronchiolitis obliterans: <input type="checkbox"/> no <input type="checkbox"/> yes
Patient is on Diltiazem	<input type="checkbox"/> no <input type="checkbox"/> yes				Evidence for transplant coronary artery disease: <input type="checkbox"/> no <input type="checkbox"/> yes
					If yes: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe

Current weight of the patient: _____ kg

Height of the patient: _____ cm (if < 19 years)

Is this patient **currently a smoker?** no yes

Is this patient **currently treated for diabetes?** no yes

Is patient on "**Statin**" treatment? no yes

Current Serum Cholesterol Total: < 200 mg/dL (< 5.0 mmol/L)
 200 - 250 mg/dL (5.0 - 6.5 mmol/L)
 250 - 300 mg/dL (6.5 - 8.0 mmol/L)
 > 300 mg/dL (> 8.0 mmol/L)

HDL: _____ mg/dL or _____ mmol/L

LDL: _____ mg/dL or _____ mmol/L

Has this patient been **hospitalized because of infection** during the last year? no yes

If yes: bacterial _____
 fungal specify bacterium _____
 viral CMV Herpes Other _____
specify virus _____

Date of first hospitalization: _____
Day Month Year

Does this patient **currently** show evidence of:

Osteonecrosis no yes

Osteoporosis no yes If yes: mild moderate severe

Hip Fracture (ever) no If yes: Year _____

Other type of **bone pain** no yes

Cataract no yes

Date

Signature

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