

CTS COLLABORATIVE TRANSPLANT STUDY

Immunosuppressive Follow up **Years** after Transplantation

Transplant Center _____	Recipient Name (Last, First) _____	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	Dose/day	Trough Level		
Cyclosporine-Neoral	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL		
or Cyclosporine generic	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL		
Tacrolimus/FK506	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL		
Sirolimus/Rapamycin	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL		
Everolimus/Certican	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg	_____ ng/mL		
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: _____			

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

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

If yes: bacterial _____ specify bacterium

fungal _____

viral CMV Herpes Other _____ specify virus

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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