

CTS COLLABORATIVE TRANSPLANT STUDY

KIDNEY TRANSPLANT

Basic Follow-Up

Transplant Center _____

Recipient Name (Last, First) or ID _____

_____/_____/_____
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 µmol/L)
- B = good graft function (serum creatinine 130 - 259 µmol/L)
- C = mediocre graft function (serum creatinine 260 - 400 µmol/L)
- D = poor graft function, but no chronic dialysis (serum creatinine > 400 µmol/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

Pre- and Post-Transplant Malignant Tumors

	1. Diagnosis	2. Diagnosis	3. Diagnosis
Diagnosis Date (dd/mm/yyyy)	_____/_____/_____	_____/_____/_____	_____/_____/_____
Diagnosis Text	-----	-----	-----
ICD-10 Code	-----	-----	-----
Overall Stage	I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/>	I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/>	I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/>
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 _____

Completed by _____

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