**TRANSITION MEDICAL SUMMARY**

**HEART TRANSPLANT**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_**

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| **INDICATION FOR HEART TRANSPLANT** |

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| **DATE(S) OF TRANSPLANT(S)** |

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| **TYPE OF TRANSPLANT** | | | | |
|  | Orthotopic |  | Heterotopic | **Comments:** |
|  | Bicaval |  | Biatrial | **Comments:** |

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| **INITIAL TRANSPLANT SURGICAL OPERATIVE NOTES** |

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| **TRANSPLANT HISTORY** | |
| Pretransplant sensitization |  |
| Donor HLA typing |  |
| Ischemic time |  |
| ABO compatibility |  |
| CMV status |  |
| EBV status |  |
| MCS prior to transplant |  |
| HLA typing |  |
| Induction therapy |  |

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| **CURRENT MEDICATIONS (and important historical changes in medications)** |

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| **ALLERGIES** |

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| **CURRENT WEIGHT** |

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| **LABORATORY DATA** |

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| **TRANSPLANT COMPLICATIONS** | | | | | |
| Rejection *(date, type, treatment)* | *(confirm type: acute cellular, antibody-mediated, biopsy-negative, and/or hemodynamic compromise requiring inotrope support)* | | | | |
| Surgical complications |  | | | | |
| Graft vasculopathy *(EBV/PTLD, CMV)* |  | | | | |
| Infection history |  | | | | |
| DSA | MFI/Complement Fixation? |  | yes |  | no |
| Other |  | | | | |

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| **CATH/HISTOLOGY DATA** | | | | | | | |
| Last catheterization | Date: | Type: | RAP | PAP | PCWP | CI | SVO2 |
| Last coronary angiogram | Date: | | | | | | |
| Last biopsy | Date: | | | | | | |
| Last echocardiogram LVEF | Date: | | | | | | |

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| **ADDITIONAL MEDICAL ISSUES** |

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| **RECENT AND/OR IMPORTANT HOSPITALIZATIONS** |

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| **PSYCHOSOCIAL ISSUES** | |
| School/Employment |  |
| Family/Housing |  |
| Adherence |  |
| Mental Health |  |
| Physical Status |  |

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| **INSURANCE STATUS** | |
| Provider |  |
| ID number |  |
| Phone |  |

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| **PATIENT CONTACT INFORMATION** | |
| Home phone |  |
| Cell phone |  |
| Home address |  |
| Secondary contact name |  |
| Secondary contact phone number |  |

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| **PEDIATRIC PROVIDER CONTACT INFORMATION** | |
| Pediatric Transplant Coordinator name |  |
| Office phone number |  |
| Office fax number |  |
| Office location |  |

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| **PRIMARY CARE PROVIDER CONTACT INFORMATION** | |
| Physician name |  |
| Office phone number |  |
| Office fax number |  |
| Office location |  |