**Heart-Lung Candidate Summary**

|  |  |
| --- | --- |
| **OSOTC Patient Number:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT DEMOGRAPHICS** | | | | |
| **Initials:** | **Birth Date:** | **Height:** | **Weight:** |  |
| **Gender:** M  F | **ABO:** A  B  AB  O | **Race:** | **Transplant#:** |  |

|  |  |
| --- | --- |
| **PATIENT STATUS** | |
| **MEDICAL DIAGNOSIS:** | **NY CHF Functional Class:** |
| **MEDICAL HISTORY** (Please indicate nutritional status, infection, ascites, variceal hemorrhage, encephalopathy, etc.): | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Laboratory Data** | | | | | |
| **Renal** | Patient | | | Lab Date | Normal Range |
| BUN | |  |  | |  |
| Creatinine | |  |  | |  |
| **Hepatic** | Patient | | | Lab Date | Normal Range |
| AST (SGOT) |  | | |  |  |
| ALT (SGPT |  | | |  |  |
| Alk Phos |  | | |  |  |
| Bilirubin |  | | |  |  |
| Albumin |  | | |  |  |
| Protein |  | | |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Cardiac Catheterization** | | | | |
| Right Atrium |  | | | |
| Right Ventricle |  | | | |
| Pulmonary Artery (sys/dias/mean) |  | | | |
| Pulmonary Artery Wedge (mean) |  | | | |
| Woods Units |  | | | |
| Left Ventricle |  | | | |
| Left Ventricular end diastolic pressure |  | | | |
| Aortic Pressure |  | | | |
| Cardiac Output |  | | | |
| Cardiac Index |  | | | |
| LV Ejection |  | | | |
| Pressures: | Baseline: |  | With Vasodilators: |  |
| Previous CABG | Yes  No | | | |
| Coronary Artery Disease | Yes  No | | | |

|  |
| --- |
| **Pertinent ECHO or MUGA Results** |
|  |

|  |
| --- |
| **Pertinent Chest X-Ray Results** |
|  |

|  |
| --- |
| **Electrocardiogram** |
|  |

|  |
| --- |
| **Pulmonary Function Test** |
|  |

|  |
| --- |
| **6 Minute Walk Test** |
|  |

|  |
| --- |
| **Quantitative Perfusion Scan** |
|  |

|  |
| --- |
| **Cancer Screenings**  (PSA, colonoscopy, mammogram, pap) |
|  |

|  |
| --- |
| **Smoking History & Length of Abstinence** |
|  |

|  |
| --- |
| **Psychosocial Evaluation/Quality of Life**  (Support system, informed consent, attitude about transplant, aftercare, complications, etc.): |
|  |

|  |  |  |
| --- | --- | --- |
| **Ohio Medicaid Insurance**  The Ohio Medicaid Required Information Form should be submitted along with this summary. | | |
| **Select Type:** | Standard Medicaid | Medicaid Managed Care Plan |