**Heart Candidate Summary**

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| Kidney | [ ]  | Liver | [ ]  | Other: |       |

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| **OSOTC Patient Number:** |      |

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

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| **Patient Status** |
| **Medical Diagnosis:**       |
| **UNOS Status:** 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]   | **NYHA Functional Class:**       |
| **Mechanical circulatory support:** Yes [ ]  No [ ]  Date:       Device:       Complications:      |
| **PATIENT CARE LOCATION**: [ ]  Outpatient [ ]  Inpatient not in ICU or special care unit [ ]  Inpatient in ICU or special care unit |
| **MEDICAL HISTORY** (Co-morbidities, AICD, infection, etc.): | **ICD:**       | **CRT:**       |
|       |
| **SURGICAL HISTORY** (Previous transplant surgery, CABG, valve repair, stent, etc.):      |

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| **Right Heart Catheterization** |
| **Date** | **HR** | **BP** | **RA** | **RV** | **PA (S/D/M)** | **PCWP** | **TPG** | **PVR** | **CO/CI** | **Drug?** |
|       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |

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| **Echocardiogram Results** | **Date:**          | **Not Done** [ ]  |
| **EF** | **EDD** | **MR** | **TR** | **RV** | **Comments** |
|       |       |       |       |       |       |

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| **Cardiopulmonary Exercise Test** | **Date:**          | **Not Done** [ ]  |
| **Peak VO2:**       | **%Predicted for Age:**       | **VE/VCO2:**       | **RER:**       |

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| **Pulmonary Function Test** | **Date:**          | **Not Done** [ ]  |
| **FVC** | **%FVC** | **FEV1** | **%FEV1** | **%DLCO** | **pH** | **pO2** | **pCO2** | **HCO3** | **FiO2** | **Sat** |
|       |       |       |       |       |       |       |       |       |       |       |

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| **Cancer Screening Results** |
| **MALIGNANCY HISTORY:**       |

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| **Laboratory Results** | **Date:**          | **Not Done** [ ]  |
| **WBC:****Hgb:****HCT:****Plts:****PT:****INR:** |                                | **Sodium:****Potassium:****BUN:****Creatinine:****Creat.Clear:****Renal Failure:** |                          Yes [ ]  No [ ]  | **T.Bili:****Alk Phos:****AST:****ALT:****T.Protein:****Albumin:** |                                | **TSH:****Cholesterol:****Triglycerides:****HDL:** |                      |

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

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