**Pediatric Heart Candidate Summary**

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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:**       | **NYHA Functional Class:**       |
| **Mechanical Circulation Support Device:** Yes [ ]  No [ ]  **Device:**       **Date:**       |
| **UNOS Status:** 1A [ ]  1B [ ]  2 [ ]  7 [ ] **Intubated:** [ ]  Yes [ ]  No**On dialysis:** [ ]  Yes [ ]  No**Pulmonary artery catheter in place:** [ ]  Yes [ ]  No | **Patient care location**: [ ]  Outpatient[ ]  Inpatient not in ICU or special care unit[ ]  Inpatient in ICU or special care unit |
| **MEDICAL HISTORY** (Please indicate co-morbidities, AICD, infection, etc.):      |
| **SURGICAL HISTORY** (Please indicate previous transplant surgery, CABG, valve repair, stent, etc.):      |

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| **Right Heart Catheterization** | **Date:**        | **Not Done** [ ]  |
| **Date** | **HR** | **BP** | **RA** | **RV** | **PA (S/D/M)** | **PCWP** | **TPG** | **PVR** | **CO/CI** | **Drug?** |
|       |       |       |       |       |       |       |       |       |       |       |

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| **Left Heart Catheterization** | **Date:**        | **Not Done** [ ]  |
| **Date** | **HR** | **BP** | **LA** | **LV** | **PA (S/D/M)** | **PCWP** | **TPG** | **PVR** | **CO/CI** | **Drug?** |
|       |       |       |       |       |       |       |       |       |       |       |

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| **Echocardiogram Results** | **Date:**        | **Not Done** [ ]  |
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| **Electrocardiogram Results** | **Date:**        | **Not Done** [ ]  |
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| **ABO Isohemagglutinin Titer Results** |  | **Not Done** [ ]  |
|  | Highest titer, Date:       | Most recent titer, Date:       |
| Anti-A titer, IGM |       |       |
| Anti-A titer, IGG |       |       |
| Anti-B titer, IGM |       |       |
| Anti-B titer, IGG |       |       |
| Has candidate received any treatments that may have reduced the titer values to 1:16 or less within 30 days of when the blood sample was collected? | **[ ]** Yes, treatment received       **[ ]** No |

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| **Pertinent Chest X-Ray Results** | **Date:**        | **Not Done** [ ]  |
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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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| **Laboratory Results** | **Date:**        | **Not Done** [ ]  |
| **WBC:****Hgb:****HCT:****Plts:****PT:****INR:****Sodium:****Potassium:** |                                          | **BUN:****Creatinine:****Creat.Clear:****Renal Failure:****T.Bili:****Alk Phos:****AST:** |                     (Y/N)                | **ALT:****T.Protein:****Albumin:****Cholesterol:****Triglycerides:****HDL:****TSH:** |                                     | **Hep A:****Hep B:****Hep C:****CMV+:****EBV+:****Rh:****% PRA:** |                                     |

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| **Current Medications** |  |
| **List all medications:** | **Administered:** |
|                                                                             | [ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other[ ]  Enteral [ ]  IV [ ]  Ventilator [ ]  Other |

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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 [ ]   |