**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 |