**Liver Candidate Summary**

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| Kidney |  | Pancreas |  | 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:** | **MELD/PELD/Status:** |
| **MEDICAL HISTORY** (Please indicate nutritional status, infection, ascites, variceal hemorrhage, encephalopathy, etc.): | |

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| **PATIENT SYMPTOMS** | | |
| **Fatigue:** Yes  No | **Ascites:** Yes  No | **Hematemesis:** Yes  No |
| **Cardiac Issues:** Yes  No | **Pulmonary Issues:** Yes  No | **Dialysis:** Yes  No |

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| **HCV** | | | |
| **HCV:** Yes  No | **PCR:** | **Genotype:** | **Treatment:** Yes  No |

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| **HCC** | | | | | |
| **HCC:** Yes  No | **Size of largest lesion:** | **No. of Lesions:** | | | **Total Size:** |
| **Is this a resection candidate?** Yes  No  If not, why not? | | | | | |
| **Diagnosis confirmed by: Biopsy:** Yes  No  If not, why not? | | | | | |
| **alphafetaprotein (please enter value):**       NG/ml | | | | | |
| **CT:** Yes  No | **MRI:** Yes  No | **Ultrasound:** Yes  No | | | |
| **HCC Treated:** Yes  No | **Chemoembolization:** Yes  No | | **RFA:** Yes  No | **Resection:** Yes  No | |

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| **LABORATORY DATA** | | | |
| **Renal** | Patient | Lab Date |  |
| BUN |  |  |  |
| Creatinine |  |  |  |
| **Hepatic** | Patient | Lab Date |  |
| AST (SGOT) |  |  |  |
| ALT (SGPT |  |  |  |
| Alk Phos |  |  |  |
| Amylase |  |  |  |
| T Bili |  |  |  |
| PT |  |  |  |
| PTT |  |  |  |
| Albumin |  |  |  |
| INR |  |  |  |
| **Other** | Patient | Lab Date |  |
| WBC |  |  |  |
| HGB/HCT |  |  |  |
| Platelets |  |  |  |
| Calcium |  |  |  |
| Glucose |  |  |  |
| T Protein |  |  |  |
| Sodium |  |  |  |
| Potassium |  |  |  |
| Chloride |  |  |  |
| Ammonia |  |  |  |
| **Serology** | Patient | Lab Date |  |
| Anti HAV |  |  |  |
| HBsAg |  |  |  |
| Anti HBs |  |  |  |
| HBeAg |  |  |  |
| HBV DNA |  |  |  |
| Anti HBc |  |  |  |
| Anti HBe |  |  |  |
| Anti HCV |  |  |  |
| Method |  |  |  |
| HCV RNA |  |  |  |
| CMV IGG |  |  |  |
| CMV IGM |  |  |  |
| HIV |  |  |  |

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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 |