Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

TRANSPLANT RECIPIENT HEALTH SUMMARY

Date initiated _____
Date of most recent update _____ **Current age: _____ yr**

Prepared by			
Nurse		Staff Physician	
Resident		Other	

MAIN DIAGNOSIS	**Date of Diagnosis**

SUPPLEMENTARY INFORMATION

OTHER MAJOR DIAGNOSES	**Date**	**Comments**
1.		
2		

SUPPLEMENTARY INFORMATION

CURRENT MEDICATIONS	**DOSE and FREQUENCY**
1.	
2.	
3.	
4.	

ALLERGIES /Medication Intolerances / Adverse Reactions
1.
2.

ACTIVE HEALTH ISSUES		
DIAGNOSIS	**DATE**	**COMMENTS**
1.		
2.		
3.		
4.		

SUPPLEMENTARY INFORMATION

OTHER PERTINENT PAST MEDICAL and SURGICAL HISTORY		
DIAGNOSIS &/ OR PROCEDURE	**DATE**	**COMMENTS**
1.		
2.		
3.		
4.		

DIALYSIS HISTORY		
MODALITY	**DATE**	**COMMENTS**

DIALYSIS COMPLICATION		
TYPE OF COMPLICATION	**DATE**	**COMMENTS**

SUPPLEMENTARY INFORMATION

Dialysis Access History		
CATHETER TYPE & SITE	**DATE**	**COMMENTS**

SUPPLEMENTARY INFORMATION

RENAL TRANSPLANT HISTORY

CURRENT TRANSPLANT **Date**

Donor type	**Allograft Placement**
Living Related ☐ Living Unrelated ☐ Deceased ☐	Extraperitoneal ☐ Intraperitoneal ☐ RLQ ☐ LLQ ☐

HLA

Recipient	A	B	DR	DP/ DQ
Donor	A	B	DR	DP/ DQ

Highest PRA pre-transplant **Test Method:**

Antibody specificities

IMMUNOSUPPRESSION

Induction: Thymoglobulin ☐ Basiliximab ☐ Daclizumab ☐ Other:

Initial maintenance immunosuppression

Corticosteroid withdrawal protocol: **YES** ☐ **NO** ☐

Current maintenance immunosuppression

Target Levels:

☐ **Tacrolimus trough_____** ☐ **Sirolimus trough_____** ☐ **Other_____**

Reasons for immunosuppression changes

REJECTION EPISODES

Date	**Biopsy Findings**	**DSA**	**Treatment**
1.			
2.			
3.			

OTHER RELEVANT BIOPSIES

Date	**Biopsy Findings**	**Comments**

VIRAL ISSUES
PRE-TRANSPLANT VIRAL ISSUES
Recipient Pre-transplant Viral Status **EBV Neg ☐ Pos ☐ CMV Neg ☐ Pos ☐ BK Neg ☐ Pos ☐ Unknown ☐**
Donor Viral Status **EBV Neg ☐ Pos ☐ Unknown ☐ CMV Neg ☐ Pos ☐ BK Neg ☐ Pos ☐ Unknown ☐**
POST TRANSPLANT VIRAL ISSUES
EBV Infection / Disease Yes ☐ No ☐ **Details**
CMV Infection / Disease Yes ☐ No ☐ **Details**
BK Infection / Disease Yes ☐ No ☐ **Details**
JC Infection / Disease Yes ☐ No ☐ **Details**
Other serious viral infection Yes ☐ No ☐ **Details**

MOST RECENT NUCLEIC ACID TEST (NAT) RESULTS			
EBV	**Date**	**CMV**	**Date**
BK	**Date**	**Other**	

PRIOR RENAL TRANSPLANT(S)				
1st TRANSPLANT				**Date**
Donor type			**Allograft Placement**	
Living Related ☐ Living Unrelated ☐ Deceased ☐			Extraperitoneal ☐ Intraperitoneal ☐ RLQ ☐ LLQ ☐	
Donor HLA	A	B	DR	DP/ DQ
Cause of graft loss				
2nd TRANSPLANT				**Date**
Donor type			**Allograft Placement**	
Living Related ☐ Living Unrelated ☐ Deceased ☐			Extraperitoneal ☐ Intraperitoneal ☐ RLQ ☐ LLQ ☐	
Donor HLA	A	B	DR	DP/ DQ
Cause of graft loss				

IMMUNIZATIONS
(or optional: Please see attached immunization record)

RELEVANT FAMILY HISTORY

MOST RECENT PHYSICAL EXAMINATION			
Name of Physician who completed exam			Date:
Wt (kg)	Ht (cm)	BMI	BSA (m^2)
BP	Cuff size	Method: Auscultatory ☐	Oscillometric ☐
Remainder of exam			

CURRENT PEDIATRIC PHYSICIAN(S)			
NAME	**Specialty**	**ADDRESS**	**Phone/ Email/ Fax**

FAMILY PHYSICIAN		
NAME	**ADDRESS**	**Phone/ Email/ Fax**

ADULT PHYSICIAN REFERRALS MADE			
NAME	**Specialty**	**ADDRESS**	**Phone/ Email/ Fax**

OTHER PROFESSIONALS	NAME	PHONE NUMBER	FAX/EMAIL
1.PHARMACY			
2.			

RELEVANT SOCIAL HISTORY	
Languages spoken	
Living arrangements	
School level	
Habits (substance use, cigarettes)	
Sexual history	
Level of comprehension for instructions	
Parental involvement	
Community resources	
Current adherence issues	
Other	

READINESS CHECKLIST/ASSESSMENT ATTACHED

Yes ☐ No ☐ To follow ☐

AREAS IN NEED OF SPECIAL ATTENTION OR FOLLOW-UP
1. Pain threshold
2. Preferences for special treatments / investigations
3.Level of comprehension
4.
5.

CONTACT INFORMATION			
LEGAL DECISION MAKER			
Patient ☐	**Other ☐ Name**	**Relationship**	
Home phone	**Work phone**	**Cell phone**	**Email**
Preferred method of contact			
NEXT OF KIN			
Name		**Relationship**	
Home phone	**Work phone**	**Cell phone**	**Email**

SUPPLEMENTARY HEALTH AND PRESCRIPTION INSURANCE			
Company Name	**Certificate #**	**Group #**	**Contact information**
Medication coverage by RAMQ Yes ☐ No ☐			

ADULT SITE APPOINTMENT(S) BOOKED		
1. Name	Specialty	Address
Phone	Appointment Date	Date patient notified
2. Name	Specialty	Address
Phone	Appointment Date	Date patient notified
3. Name	Specialty	Address
Phone	Appointment Date	Date patient notified

REPORTS TO BE ATTACHED	COMMENTS
Medical Imaging	
Pathology	
Operative reports	
Relevant protocols	
Recent Blood and Urine Tests	
Specialty Discharge Summaries	

SIGNATURES			
NURSE			
Signature	**Print name**	**# Licence**	Date
RESIDENT			
Signature	**Print name**	**# Licence**	Date
STAFF PHYSICIAN			
Signature	**Print name**	**# Licence**	Date