

MALAYSIAN HEART AND LUNG TRANSPLANT NOTIFICATION FORM

Instruction: Where check boxes are provided, check (✓) one or more boxes. Where radio buttons are provided, check (✓) one box only. NA refers to Not Applicable. Fill in the date with dd/mm/yyyy format.

Office use:	/	
Centre:		

SECTION 1 : PROVIDER INFORMATION

1a. Transplant Centre Provider Number:			
1b. Transplant Centre Name : *			
2a. Follow-up Hospital Provider Number:			
2b. Follow-up Hospital Name: *			
3. Chart Number:		4. 9IS #: (UNOS use only)	

SECTION 2 : RECIPIENT DETAILS

1. Name : * (Please print in capital letters)				2. Registration Number:		
3. NRIC : *	MyKad: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> - <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> - <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Old IC: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>				
	Other ID document No: <input style="width: 100%; border: 1px solid black;" type="text"/>	Specify document type (if others):				
	<input type="radio"/> Registration number <input type="radio"/> Mother's I/C <input type="radio"/> Armed Force ID <input type="radio"/> Date of Birth <input type="radio"/> Passport <input type="radio"/> Father's I/C <input type="radio"/> Work Permit # <input type="radio"/> Lab number <input type="radio"/> Others					
<12 years: Birth cert #: <input style="width: 50%; border: 1px solid black;" type="text"/>		I/C Guardian: Mother / Father <input style="width: 50%; border: 1px solid black;" type="text"/>		Sibling ranking: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>		
4a. Date of Birth: * (dd/mm/yyyy)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input type="checkbox"/> Not available <small>(autofill if MyKad is available)</small>	4b. Age: (autocalculate)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	5. Gender:	<input type="radio"/> Male <input type="radio"/> Female
6. Ethnic group: *	<input type="radio"/> Malay <input type="radio"/> Indian <input type="radio"/> Bumiputra Sarawak, specify: _____ <input type="radio"/> Chinese <input type="radio"/> Bumiputra Sabah, specify: _____ <input type="radio"/> Others, specify: _____					
7. Religion:	<input type="radio"/> Islam <input type="radio"/> Buddhism <input type="radio"/> Christianity <input type="radio"/> Hinduism <input type="radio"/> Others, specify: _____ <input type="radio"/> Unknown					
8. Marital Status:	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Unknown					
9. Education Level:	<input type="radio"/> Uneducated <input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Tertiary <input type="radio"/> Others, specify: _____ <input type="radio"/> Unknown					
10. Date added to wait list:	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> (dd/mm/yyyy)					
11. Date of transplant: *	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> (dd/mm/yyyy)					
12. State of residence:	<input type="radio"/> Johor Darul Takzim <input type="radio"/> Pahang Darul Makmur <input type="radio"/> Sarawak <input type="radio"/> Wilayah Persekutuan Labuan, Sabah <input type="radio"/> Kedah Darul Aman <input type="radio"/> Perak Darul Ridzuan <input type="radio"/> Selangor Darul Ehsan <input type="radio"/> Wilayah Persekutuan Putrajaya <input type="radio"/> Kelantan Darul Naim <input type="radio"/> Perlis Indera Kayangan <input type="radio"/> Terengganu Darul Iman <input type="radio"/> Melaka <input type="radio"/> Pulau Pinang <input type="radio"/> Wilayah Persekutuan Kuala Lumpur <input type="radio"/> Negeri Sembilan Darul Khusus <input type="radio"/> Sabah <input type="radio"/> Not applicable - Foreign					
13. Country of residence:	<input type="radio"/> Malaysia <input type="radio"/> Others, specify: _____ <input type="radio"/> Not available					
14. Immediate Pretransplant Employment status:	<input type="radio"/> Student <input type="radio"/> Working Part Time Reason Unknown <input type="radio"/> Not Working, Reason Unknown <input type="radio"/> Working full time <input type="radio"/> Not Working By Choice <input type="radio"/> Working Part Time By Choice <input type="radio"/> Not Working Due to Disease <input type="radio"/> Retired <input type="radio"/> Working Part Time Due to Disease <input type="radio"/> Not Working Unable to Find Employment <input type="radio"/> Employment Status Unknown					

SECTION 3 : IMMEDIATE PRETRANSPLANT CLINICAL INFORMATION

1. ABO Blood Group:	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> AB <input type="radio"/> O <input type="radio"/> Not available				
2. Weight (kg):	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>				
3. Height (cm):	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>				
4a. Heart diagnosis:	<input type="radio"/> Ischaemic Cardiomyopathy <input type="radio"/> Restrictive Cardiomyopathy <input type="radio"/> Hypertrophic Cardiomyopathy <input type="radio"/> Idiopathy Dilated Cardiomyopathy <input type="radio"/> End Stage valvular heart disease <input type="radio"/> Unknown <input type="radio"/> Other, specify: _____				
4b. Lung diagnosis / specify:	(Use Code) <input style="width: 100%; border: 1px solid black;" type="text"/>				

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SECTION 3 : IMMEDIATE PRETRANSPLANT CLINICAL INFORMATION (Continue)

5a. Medical condition:	<input type="radio"/> Patient in Intensive Care Uni <input type="radio"/> Hospitalized, but not in Intensive Care Unit <input type="radio"/> Not hospitalized																	
5b. Patient on life support:	<input type="checkbox"/> ECMO	Duration:	<input style="width: 100px;" type="text"/> hrs															
	<input type="checkbox"/> IABP	Duration:	<input style="width: 100px;" type="text"/> hrs															
	<input type="checkbox"/> PGE	Duration:	<input style="width: 100px;" type="text"/> days															
	<input type="checkbox"/> IV Inotropes	Duration:	<input style="width: 100px;" type="text"/> days															
	<input type="checkbox"/> Nasal Ventilation	Duration:	<input style="width: 100px;" type="text"/> days															
	<input type="checkbox"/> Noninvasive Ventilation, CPAP	Duration:	<input style="width: 100px;" type="text"/> days															
	<input type="checkbox"/> Noninvasive Ventilation, BiPAP	Duration:	<input style="width: 100px;" type="text"/> days															
	<input type="checkbox"/> Long Term Oxygen Therapy	Duration:	<input style="width: 100px;" type="text"/> days															
	<input type="checkbox"/> Other mechanism Specify: _____																	
	<input type="checkbox"/> LVAD →	<table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <tr> <td><input type="radio"/> HeartMate IP</td> <td><input type="radio"/> Novacor PCq</td> <td><input type="radio"/> Micromed DeBakey</td> <td><input type="radio"/> Medos</td> </tr> <tr> <td><input type="radio"/> HeartMate VE</td> <td><input type="radio"/> Thoratec</td> <td><input type="radio"/> Jarvik 2000</td> <td><input type="radio"/> Toyobo</td> </tr> <tr> <td><input type="radio"/> HeartMate II</td> <td><input type="radio"/> Arrow Lionheart</td> <td><input type="radio"/> Pittsburgh AB180</td> <td><input type="radio"/> Type unspecified</td> </tr> <tr> <td><input type="radio"/> Novacor PC</td> <td><input type="radio"/> HeartSaver VAD</td> <td><input type="radio"/> Berlin Heart</td> <td></td> </tr> </table>		<input type="radio"/> HeartMate IP	<input type="radio"/> Novacor PCq	<input type="radio"/> Micromed DeBakey	<input type="radio"/> Medos	<input type="radio"/> HeartMate VE	<input type="radio"/> Thoratec	<input type="radio"/> Jarvik 2000	<input type="radio"/> Toyobo	<input type="radio"/> HeartMate II	<input type="radio"/> Arrow Lionheart	<input type="radio"/> Pittsburgh AB180	<input type="radio"/> Type unspecified	<input type="radio"/> Novacor PC	<input type="radio"/> HeartSaver VAD	<input type="radio"/> Berlin Heart
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<input type="checkbox"/> RVAD →	<table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <tr> <td><input type="radio"/> Thoratec</td> <td><input type="radio"/> Medos</td> <td><input type="radio"/> Abiomed BVS</td> <td><input type="radio"/> Type unspecified</td> </tr> <tr> <td><input type="radio"/> Berlin Heart</td> <td><input type="radio"/> Toyobo</td> <td><input type="radio"/> BioMedicus</td> <td></td> </tr> </table>		<input type="radio"/> Thoratec	<input type="radio"/> Medos	<input type="radio"/> Abiomed BVS	<input type="radio"/> Type unspecified	<input type="radio"/> Berlin Heart	<input type="radio"/> Toyobo	<input type="radio"/> BioMedicus									
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<input type="checkbox"/> TAH →	<table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <tr> <td><input type="radio"/> Cardiowest</td> <td><input type="radio"/> AbioCor</td> <td><input type="radio"/> Type unspecified</td> </tr> </table>		<input type="radio"/> Cardiowest	<input type="radio"/> AbioCor	<input type="radio"/> Type unspecified													
<input type="radio"/> Cardiowest	<input type="radio"/> AbioCor	<input type="radio"/> Type unspecified																
5c. Date of implantation:	<input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (dd/mm/yyyy)																	
6. Functional Status:	(How does the patient perform activities of daily living? Select one) <input type="radio"/> No activity limitations. (NYHA Class I or Class II) <input type="radio"/> N/A Patient hospitalized <input type="radio"/> Performs activities of daily living with some assistance. (NYHA Class III) <input type="radio"/> Unknown <input type="radio"/> Performs activities of daily living with total assistance. (NYHA Class IV)																	
7. Pretransplant Serology:	a. HIV		<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
	b. CMV	IgG:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		IgM:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		DNA:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
	c. Hep B	Core Antibody:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		Surface Antigen:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		HBV DNA:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
	d. Hep C	Antibody Screen:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		RIBA Test:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		HCV RNA:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
	e. EBV	IgG:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		IgM:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
		DNA:	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available															
	f. Most recent Hemodynamics & Inotropes / Vasodilators:	PA (sys) actual:	<input style="width: 50px;" type="text"/> mm/Hg	Inotropes/ Vasodilators: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available														
		PA (dia) estimate:	<input style="width: 50px;" type="text"/> mm/Hg	Inotropes/ Vasodilators: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available														
		PA (mean):	<input style="width: 50px;" type="text"/> mm/Hg	Inotropes/ Vasodilators: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available														
		PCW (mean):	<input style="width: 50px;" type="text"/> mm/Hg	Inotropes/ Vasodilators: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available														
		CO:	<input style="width: 50px;" type="text"/> L/min	Inotropes/ Vasodilators: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available														
Ejection Fraction:		<input style="width: 50px;" type="text"/> %	Inotropes/ Vasodilators: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available															

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SECTION 3 : IMMEDIATE PRETRANSPLANT CLINICAL INFORMATION (Continue)

8a. Most recent Serum Creatinine:	<input style="width: 90%;" type="text"/>	μmol/L
8b. Most recent Serum Total Bilirubin:	<input style="width: 90%;" type="text"/>	μmol/L
8c. Oxygen requirement at rest:	<input style="width: 90%;" type="text"/>	L/min
8d. Chronic Steroid Use:	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available	
8e. FEV1(L)/FVC(L):	<input style="width: 40%;" type="text"/> / <input style="width: 40%;" type="text"/>	
8f. pO₂	on room air:	on oxygen:
9. Pulmonary Status	a. FVC:	<input style="width: 60%;" type="text"/> % Predicted
	b. FEV1:	<input style="width: 60%;" type="text"/> % Predicted
	c. pCO₂:	<input style="width: 60%;" type="text"/> mmHg
10. General Medical Factors	a. Diabetes	<input type="radio"/> No Diabetes <input type="radio"/> Diabetes, Dependency Unknown <input type="radio"/> Insulin Dependent Diabetes <input type="radio"/> Unknown <input type="radio"/> Non-Insulin Dependent Diabetes
	b. Dialysis	<input type="radio"/> No Dialysis <input type="radio"/> Peritoneal Dialysis <input type="radio"/> Hemodialysis <input type="radio"/> Unknown
	c. Peptic Ulcer Disease	<input type="radio"/> No <input type="radio"/> Yes, Drug Treatment Unknown <input type="radio"/> Yes, Drug Treated <input type="radio"/> Unknown <input type="radio"/> Yes, Not Drug Treated
	d. Unstable Angina / Coronary Artery Disease / Myocardial Infarction:	<input type="radio"/> No <input type="radio"/> Stable CAD <input type="radio"/> Old MI <input type="radio"/> Unstable CAD <input type="radio"/> Unknown
	e. Drug Treated Systemic Hypertension:	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	f. Symptomatic Cerebrovascular Disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	g. Symptomatic Peripheral Vascular Disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	h. Drug Treated COPD	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	i. Pulmonary Embolism (within last 6 months)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	j. Any Previous Transfusions :	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	k. Any Previous Malignancy (Exclude non-melanoma skin cancer)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	l. PRA	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available
	m. Any cigarette use within last 6 months	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
11. Heart Medical Factors	a. Sudden Death	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	b. Antiarrhythmics	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	c. Amiodarone	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	d. Implantable defibrillator	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	e. Cardiac Resynchronisation Therapy	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	f. Exercise oxygen consumption:	<input style="width: 60%;" type="text"/> ml/min/kg

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SECTION 3 : IMMEDIATE PRETRANSPLANT CLINICAL INFORMATION (Continue)

12. Events Occurring to Listing for Transplant	a. Pneumothorax	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	b. Infection requiring IV drug therapy (within two weeks prior to listing)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	c. Left ventricular remodeling	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	d. Pneumoreduction	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	e. Transmyocardial revascularization (TMR)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	f. Sternotomy	<input type="radio"/> None	<input type="radio"/> 1	<input type="radio"/> +1	<input type="radio"/> Unknown
	g. CABG	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	h. Thoracotomy: Left	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	i. Thoracotomy: Right	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	j. Pleurodesis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
13. Lung Medical Factors	a. IV Treated Pulmonary Sepsis Episodes > 2 in last 12 months	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	b. Corticosteroid Dependency > 5 mg/day	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	c. Six minute walk distance < 150 ft.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	d. Pan-Resistant Bacterial Infection	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
14. HLA Typing:	a. Method:	<input type="radio"/> Serology <input type="radio"/> Other, specify: _____ <input type="radio"/> DNA <input type="radio"/> Not available			
	b. Typing:	A:		B:	DR:

SECTION 4 : TRANSPLANT CLINICAL INFORMATION

1. Multiple Organ Recipient:	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available <div style="border: 1px dashed black; padding: 5px; display: inline-block;"> check all organs that apply <input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Intestine <input type="checkbox"/> Pancreas <input type="checkbox"/> Pancreas Islets <input type="checkbox"/> Bone Marrow </div>
2a. Procedure Type:	<input type="radio"/> Ortho Heart <input type="radio"/> Heart Lung <input type="radio"/> Single Right Lung <input type="radio"/> En-Bloc Double Lung <input type="radio"/> Hetero Heart <input type="radio"/> Single Left Lung <input type="radio"/> Bilateral Sequential Lung <input type="radio"/> Others: _____
2b. Procedure Information (Heart only):	<input type="radio"/> Orthotopic Bicaval <input type="radio"/> Heterotopic <input type="radio"/> Orthotopic Traditional
3. Total Organ Ischaemic Time:	<input type="checkbox"/> Heart → <input style="width: 50px;" type="text"/> Min <input type="checkbox"/> Left Lung → <input style="width: 50px;" type="text"/> Min <input type="checkbox"/> Heart - Lung → <input style="width: 50px;" type="text"/> Min <input type="checkbox"/> Right Lung → <input style="width: 50px;" type="text"/> Min

SECTION 5 : POST TRANSPLANT CLINICAL INFORMATION

1. Events Prior to Discharge:	a. Any Drug Treated Rejection	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	b. Any Drug Treated Infection	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	c. Stroke	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	d. Dialysis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	e. Re-Operation, Hemorrhage	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	f. Re-Operation, Other	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	g. Other Surgical Procedures	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	h. Prolonged Graft Dysfunction	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	i. Permanent Pacemaker	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	j. Bronchopleural Fistula	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available
	k. Airway Dehiscence	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="radio"/> Not available

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SECTION 6 : PATIENT STATUS AT DISCHARGE

1. Patient Status	<p>a. Date of Report or Death <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</p> <p>b. Status:</p> <p><input type="radio"/> Living</p> <p><input type="radio"/> Dead → <table border="1" style="border-style: dashed; border-width: 1px; padding: 5px;"> <tr> <td style="background-color: #cccccc; padding: 2px;">Cause of Death: (Use code)</td> <td style="width: 150px; height: 20px;"></td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Specify:</td> <td style="width: 150px; height: 20px;"></td> </tr> </table></p> <p><input type="radio"/> Retransplanted prior to hospital discharge → <table border="1" style="border-style: dashed; border-width: 1px; padding: 5px;"> <tr> <td style="background-color: #cccccc; padding: 2px;">Cause:</td> <td style="padding: 2px;"><input type="radio"/> Hyperacute Rejection</td> <td style="padding: 2px;"><input type="radio"/> Other</td> </tr> <tr> <td></td> <td style="padding: 2px;"><input type="radio"/> Acute Rejection</td> <td></td> </tr> </table></p> <p><input type="radio"/> Lost</p>	Cause of Death: (Use code)		Specify:		Cause:	<input type="radio"/> Hyperacute Rejection	<input type="radio"/> Other		<input type="radio"/> Acute Rejection																											
Cause of Death: (Use code)																																					
Specify:																																					
Cause:	<input type="radio"/> Hyperacute Rejection	<input type="radio"/> Other																																			
	<input type="radio"/> Acute Rejection																																				
2. Transplant Hospitalization	<p>a. Date of discharge from transplant center <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</p> <p>b. Date of admission to transplant center <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</p> <p>c. Was patient transferred from another hospital prior to transplant?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes → <table border="1" style="border-style: dashed; border-width: 1px; padding: 5px;"> <tr> <td style="background-color: #cccccc; padding: 2px;">Date of admission to transferring hospital</td> <td style="width: 100px; height: 20px;"></td> </tr> <tr> <td></td> <td style="text-align: center; font-size: 8px;">(dd/mm/yyyy)</td> </tr> </table></p> <p><input type="radio"/> Unknown</p> <p><input type="radio"/> Not available</p>	Date of admission to transferring hospital			(dd/mm/yyyy)																																
Date of admission to transferring hospital																																					
	(dd/mm/yyyy)																																				
2. Previous transplants?	<p><input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available</p> <p>→ <table border="1" style="border-style: dashed; border-width: 1px; width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 10%;"></th> <th style="width: 10%;"></th> <th style="width: 30%;"></th> </tr> </thead> <tbody> <tr> <td style="background-color: #cccccc; padding: 2px;">Kidney</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td style="width: 50px;"></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Liver</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Pancreas (whole)</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Pancreas (islet cells)</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Heart</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Lung</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Intestine</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">Bone Marrow</td> <td style="background-color: #cccccc; padding: 2px;">No:</td> <td></td> <td style="background-color: #cccccc; padding: 2px;">Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</td> </tr> </tbody> </table></p>					Kidney	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)	Liver	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)	Pancreas (whole)	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)	Pancreas (islet cells)	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)	Heart	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)	Lung	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)	Intestine	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)	Bone Marrow	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
Kidney	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)																																		
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Pancreas (whole)	No:		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)																																		
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MALAYSIAN HEART AND LUNG TRANSPLANT NOTIFICATION FORM

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Office use:		
Centre:		

SECTION 7 : TREATMENT AT DISCHARGE

1. Immunosuppressive Information	a. Did the patient participate in any clinical research protocol for immunosuppressive medications?	<input type="radio"/> No <input type="radio"/> Yes → Specify: _____ <input type="radio"/> Unknown <input type="radio"/> Not available
2. Other Therapy	a. Photopheresis	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	b. Plasmapheresis	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	c. Total Lymphoid Irradiation (TLI)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
3. Antivirals	a. CMV Globulin	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	b. Acyclovir (Zovirax)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	c. Ganciclovir (Cytovene)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available
	d. Other:	

SECTION 8 : DONOR INFORMATION

1. Donor's Name:														
2. Donor's Age:														
3. Donor's gender:	<input type="radio"/> Male <input type="radio"/> Female													
4. Donor's Ethnic group:	<input type="radio"/> Malay <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Bumi Sabah <input type="radio"/> Bumi Sarawak <input type="radio"/> Others: _____													
5. Donor's Country:	<input type="radio"/> Malaysia <input type="radio"/> Others, specify: _____ <input type="radio"/> Not available													
6. Donor Type:	<input type="radio"/> Cadaveric <input type="radio"/> Living													
7. Date of Organ Procurement	<input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)													
8. Donor's ABO Blood Group	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> AB <input type="radio"/> O <input type="radio"/> Not available													
9. a) Donor's Weight (kg):		9. b) Donor's Height (cm):												
10. Donor's Cause of Death	<input type="radio"/> Anoxia/Cardiac Arrest <input type="radio"/> Cerebrovascular/Stroke <input type="radio"/> Other, specify: _____ <input type="radio"/> Head Trauma <input type="radio"/> CNS Tumor													
11. Donor's Mechanism of Death	<input type="radio"/> Drowning <input type="radio"/> Cardiovascular <input type="radio"/> Blunt Injury <input type="radio"/> MVA <input type="radio"/> Seizure <input type="radio"/> Electrical <input type="radio"/> Sudden Infant death <input type="radio"/> None of the Above <input type="radio"/> Drug Intoxication <input type="radio"/> Gunshot Wound <input type="radio"/> Intercranial Hemorrhage / Stroke <input type="radio"/> Asphyxiation <input type="radio"/> Stab <input type="radio"/> Death from Natural Causes													
12. Donor's Serology	a. Anti-HIV I	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	b. Anti-HIV II	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	c. Anti-HTVL I	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	d. Anti-HTVL II	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	e. RPR-VDRL	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	f. Anti-CMV	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	g. HBsAg	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	h. Anti-HBC	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	i. Anti-HCV	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
	j. EBV	<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Unknown <input type="radio"/> Not available												
13. Donor's HLA Typing:	a. Method:	<input type="radio"/> Serology <input type="radio"/> Other, specify: _____ <input type="radio"/> DNA <input type="radio"/> Not available												
	b. Typing:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">A:</td> <td style="width: 25%;"></td> <td style="width: 25%;">B:</td> <td style="width: 25%;"></td> </tr> <tr> <td>A:</td> <td></td> <td>B:</td> <td></td> </tr> </table>	A:		B:		A:		B:		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">DR:</td> <td style="width: 25%;"></td> </tr> <tr> <td>DR:</td> <td></td> </tr> </table>	DR:		DR:
A:		B:												
A:		B:												
DR:														
DR:														
14. Donor's History Of:	a. Hypertension	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available												
	b. Diabetes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available												
	c. Cancer	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available												
	d. Infection at time of Procurement	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available												
	e. Donor Coronary Disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> Not available												

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SECTION 9 : IMMUNOSUPPRESSION THERAPY

1. Steroids	a. Prednisone	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	b. Methylprednisolone	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
2. T-Cell Activation Inhibitors	a. Cyclosporin A (CSA, Sandimmune, CyA, CyS)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	b. Neoral (CyA-NOF)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	c. FK506 (Prograf, Tacrolimus)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	d. Rapamycin (RAPA, Sirolimus, Rapamune)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	e. Gengraf	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
3. Antimetabolites	a. Azathioprine (AZA, Imuran)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	b. Mycophenolate Mofetil (MMF, Cellcept, RS61443)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	c. Cytoxan (Cyclophosphamide)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	d. Methotrexate (Folex, PFS, Mexate-AQ, Rheumatex)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
4. Anti-Lymphocyte Receptor Antibodies	a. T10B9 (Medimmune)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	b. ATG (Atgam, Anti-thymocyte Globulin)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	c. NRATG / NRATS	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	d. OKT3 (Orthoclone, Muromonab)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	e. Thymoglobulin	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	f. Zenepax	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	g. Simulect	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
5. Cytokine Inhibitors	a. IL - 1 Receptor Antagonist	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	b. Anti - IL - 6	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	c. Anti - TNF	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
	d. Soluble IL - 1 Receptor	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
6. Suppressor Inducers	a. Aldesleukin (IL - 2)	<input type="checkbox"/> Induct	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Day	<input type="checkbox"/> Maint	<input type="checkbox"/> Anti-rej
7. Others, immunosuppressive medication, specify:						