SAUDI CENTER FOR ORGAN TRANSPLANTATION

المركز السعودي لزراعة الأعضاء

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Saudi Center for Organ Transplantation

استمارة تسجيل مريض الفشل الكبدي لتسجيله على قائمة الانتظار لزراعة الكبد ومتابعته

ADVANCED LIVER FAILURE PATIENT FOR LIVER TRANSPLANTATION, POST TRANSPLANT FOLLOW UP AND WAITING LIST

(This form to be filled at least every 3 months or whenever clinical status changes)

Hospital Code ☐☐☐☐☐☐ Patient No. ☐☐☐☐☐☐ SCOT No. ☐☐☐☐☐☐

اسم المريض _____ _____ _____ _____

العائلة الجد الأب رباعي

Name _____ _____ _____ _____

(First) Second Third Family

Date of filling this form: / /

1. PATIENT IDENTIFICATION

(This Section to be filled only once for every new patient)

1. Date of Birth / / 2. Sex ..... 3. Saudi I.D./Iqama No.....
4. Nationality:..... 5. Occupation:.....
6. Marital Status: Single ☐ Married ☐ Widow ☐ 7. Address: P.O. Box .....
.....
8. Blood group | A | B | AB | O | 9. Patient Tel: .....

2. CAUSE OF LIVER FAILURE

Fulminant hepatic failure		**Advanced Chronic Liver disease**	
Viral hepatitis (A, B, C, D, EBV, CMV)		Primary biliary cirrhosis	
Drug-induced liver disease (Halothane,Disulfiram, Acetaminophen etc..)		Primary sclerosing cholangitis	
Metabolic liver disease		Biliary atresia	
Wilson's disease		Idiopathic autoimmune hepatitis	
Reye's syndrome		Chronic alcoholic cirrhosis	
Massive hepatic trauma		Chronic toxic hepatitis	
Others		Chronic viral hepatitis	
		Vascular disease (Eg., Budd-Chiari syndrome Veno-occlusive disease)	
		Others	
Congenital metabolic disorders		**Liver Tumor**	
α-1 antitrypsin deficiency		Primary hepatocellular carcinoma	
Wilson's disease hyperlipoproteinemia		Other liver tumors	
Crigler-Najjar syndrome		Isolated hepatic metastatic disease (Eg., Carcinoid)	
Glycogen storage diseases		Others	
Protein C defidiency			
Oxalosis			
Others			

3. PATIENT STATUS

(This Section to be filled if changes)

ICU on ventilator		Stage IV	
ICU not on ventilator		Stage III	
In hospital		Stage II	
At Home		Stage I	
Temporary contra-indications for transplantation		Stage 0	

4. LABORATORY RESULTS

Date:

Wbc	Hb	Plts	Pt	PTT	Alb	SGOT	SGPT	Bil.	Alk Phos	γ-GT

HEPATITIS SEROLOGY

Date:

HBsAg	HBsAb	HbcAb	HCVAb	HBV (Vaccine)	HIV	Others
				Yes / No		

5. DEATH

(To be filled upon the death of patient)

Date of death / / Cause of death: .....

6. TRANSPLANTATION

(To be filled in case patient gets a liver transplant)

Date of Tx. / / Place of transplantation .....

Type of Tx. ..... Follow up hospital .....

TRANSPLANTATION DONOR INFORMATION

(If available)

Donating Hospital Name: _____ Donor's hospital File No. ☐☐☐☐☐☐☐☐

Donor Name: _____ Sex: _____ Age _____ Nationality: _____

Blood Group: | A | B | AB | O |

Donor Type: Living Donor ☐ Cadaveric Donor ☐

TRANSPLANT RECIPIENT FOLLOW-UP STATUS

(To be filled in every clinic visit or change in status)

1.	**Active**						
	SGOT		SGPT		γ-GT		Date:
	Imunosuppressive drugs:			Total daily dose			
	Cyclosporine						
	Mycophenolate (MMF)						
	Tacrolimus (FK-506)						
	Others						
2.	**Died**		(Please fill death box)				

NAME OF DOCTOR

SIGNATURE Date: