SAUDI CENTER FOR ORGAN TRANSPLANTATION

المركز السعودي لزراعة الأعضاء

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Saudi Center for Organ Transplantation

استمارة تسجيل مريض الفشل القلبي لتسجيله على قائمه الانتظار لزراعة القلب ومتابعته

ADVANCED HEART FAILURE PATIENT FOR HEART 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 HEART FAILURE

	End stage cardiac failure unresponsive to any acceptable medical or surgical treatment (L.V = EF < 20%)
	Class III or IV according NyHA
	Unresectable cardiac tumors.
	Failure to come off cardiac pulmonary bypass
	Patient is dying from acute myocardial infarction

3. PATIENT STATUS

(This Section to be filled if changes)

	Priority 1.	Patients on mechanical cardiac support or on ventilator or cannot be weaned off inotropic support or those who fail to come off cardio-pulmonary bypass.
	Priority 2.	Patients that require inotropic support, with no requirement for ventilation or mechanical cardiac support.
	Priority 3.	Patients who are on the waiting list and are waiting at home.

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4. INVESTIGATIONS

Date:

Echocardiography: _____

Cardiac angiography: _____

Others: _____

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

TRANSPLANT RECIPIENT FOLLOW-UP STATUS

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

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

NAME OF DOCTOR

SIGNATURE **Date:**

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