

International ISLET TRANSPLANT REGISTRY

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ADULT ISLET ALLOGRAFT RECIPIENT FORM

— INSTITUTION DATA —

ITR #	Islet Transplant Institution	Islet Isolation Institution
<input type="text"/>	<input type="text"/>	<input type="text"/>

— RECIPIENT DATA —

Case #	Local Code	First and Last Name	Date of Birth	Age	Sex
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> male <input type="checkbox"/> female
			MM / DD / Year	->	
Date of Tx	No. of Donors	Type of Diabetes	Diabetes Onset	Height (cm)	Weight (kg)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MM / DD / Year					
CMV <input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> ND	ABO <input type="checkbox"/> O <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB	HLA: A <input type="text"/>	B <input type="text"/>	DR <input type="text"/>	DQ <input type="text"/>

— TRANSPLANT DATA —

<input checked="" type="checkbox"/> Allograft <input type="checkbox"/> Xenograft, Species: _____	Donor Tissue <input checked="" type="checkbox"/> Adult <input type="checkbox"/> Fetal	HLA of tx'd <input type="checkbox"/> kidney <input type="checkbox"/> liver <input type="checkbox"/> pancreas	A <input type="text"/>	B <input type="text"/>
Site of Tx <input type="checkbox"/> Liver <input type="checkbox"/> Spleen <input type="checkbox"/> Kidney Capsule <input type="checkbox"/> Epiploic Flap <input type="checkbox"/> Intraperit. Cavity <input type="checkbox"/> Vasc. Prosthesis <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Intramuscular <input type="checkbox"/> Thymus <input type="checkbox"/> Others: _____	Induction IS (all IS given post tx) <input type="checkbox"/> None <input type="checkbox"/> ALS/ALG/ATG <input type="checkbox"/> OKT3 <input type="checkbox"/> Anti-IL-2 Rec Ab <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Azathioprine <input type="checkbox"/> Mycophenolate Mofetil <input type="checkbox"/> Steroids <input type="checkbox"/> Deoxyspergualin <input type="checkbox"/> Others: _____	Recipient Category <input type="checkbox"/> ITA <input type="checkbox"/> IT-BM <input type="checkbox"/> IAK <input type="checkbox"/> IAKP <input type="checkbox"/> IAKP-BM <input type="checkbox"/> SIK <input type="checkbox"/> SIK-BM <input type="checkbox"/> SIL <input type="checkbox"/> IAL <input type="checkbox"/> SIL-BM <input type="checkbox"/> SIKL <input type="checkbox"/> SIKL-BM <input type="checkbox"/> SILu <input type="checkbox"/> SIHLu <input type="checkbox"/> DIK <input type="checkbox"/> DIK-BM <input type="checkbox"/> IFPP	DR <input type="text"/>	DQ <input type="text"/>
			Dates of Previous Tx of Other Organs	
			Prev. Kidney	
			1st <input type="text"/>	
			2nd <input type="text"/>	
			3rd <input type="text"/>	
			Prev. Pancreas	
			1st <input type="text"/>	
			2nd <input type="text"/>	
			Prev. Islets	
			1st <input type="text"/>	
			2nd <input type="text"/>	

— COMMENTS ON RECIPIENT DATA —

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Last Update (MM/DD/YYYY)

Current Upd. (MM/DD/YYYY)