

International ISLET TRANSPLANT REGISTRY

Director: Professor Konrad Federlin, M.D.
Medizinische Klinik III & Poliklinik der Justus-Liebig-Universität
Rodthohl 6, 35392 Giessen, Germany.

Phone: (49)-641-702-7445, Fax:(49)-641-702-7443

RECIPIENT FORM FOR CLINICAL ISLET TRANSPLANTS

— INSTITUTION DATA —

ITR Institution # <input type="text"/>	Transplant Center <input type="text"/>	Transplant Team <input type="text"/>
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— RECIPIENT DATA —

Case # <input type="text"/>	Local Code <input type="text"/>	First and Last Initial <input type="text"/> <input type="text"/>	Date of Birth <input type="text"/>	Sex <input type="radio"/> male <input type="radio"/> female	
Date of Tx <input type="text"/>	No. of Donors <input type="text"/>	Type of DM <input type="text"/>	Age of Diabetes Onset <input type="text"/>	Height (cm) <input type="text"/>	Weight (kg) <input type="text"/>
CMV <input type="radio"/> positive <input type="radio"/> negative	ABO <input type="radio"/> 0 <input type="radio"/> B <input type="radio"/> A <input type="radio"/> AB	HLA: A <input type="text"/> B <input type="text"/>	DR <input type="text"/>	DQ <input type="text"/>	

— TRANSPLANT DATA —

<input type="checkbox"/> Autograft <input type="checkbox"/> Allograft <input type="checkbox"/> Xenograft Species: <input type="text"/>	Donor Tissue <input type="checkbox"/> Adult <input type="checkbox"/> Fetal	HLA of tx'd Kidney: A <input type="text"/> B <input type="text"/>	DR <input type="text"/>	DQ <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"/> Peritoneal Cavity <input type="checkbox"/> i.m. <input type="checkbox"/> s.c. <input type="checkbox"/> ___ <input type="checkbox"/> ___	Induction IS (all IS given peri tx) <input type="checkbox"/> None <input type="checkbox"/> Steroids <input type="checkbox"/> CsA <input type="checkbox"/> AZA <input type="checkbox"/> FK 506 <input type="checkbox"/> DSG <input type="checkbox"/> ALS/ALG/ATG <input type="checkbox"/> OK T3 <input type="checkbox"/>	Recipient Category <input type="checkbox"/> ITA <input type="checkbox"/> IAK <input type="checkbox"/> SIK <input type="checkbox"/> SIL <input type="checkbox"/> Others <input type="checkbox"/>	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 for Recipient and Donor Data

Last Date of Completion

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DONOR FORM FOR CLINICAL ISLET TRANSPLANTS (ADULT TISSUE)

— INSTITUTION AND RECIPIENT IDENTIFICATION —

Institution #	Transplant Center	Case #	Local Code	Date of Tx
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

— DONOR DATA —

Refer to Donor #	<input style="width: 90%;" type="text"/>
Age (yrs)	<input style="width: 90%;" type="text"/>
Sex	<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female
ABO	<input type="checkbox"/> O <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB
HLA: A	<input style="width: 90%;" type="text"/>
B	<input style="width: 90%;" type="text"/>
DR	<input style="width: 90%;" type="text"/>
DQ	<input style="width: 90%;" type="text"/>
Crossmatch	<input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg.
CMV	<input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg.

— Pancreas Procurement and Preservation —

Cold Perfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Perfusion- / Storage-Solution	<input style="width: 90%;" type="text"/>
Intraduct. Collag.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre Cold Storage Distension Solution	<input style="width: 90%;" type="text"/>
Cold Ischemia (min)	<input style="width: 90%;" type="text"/>

— Islet Graft Preparation —

Pretreatment	<input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres.
If Cultured: Days	<input style="width: 90%;" type="text"/>
Temp (°C)	<input style="width: 90%;" type="text"/>
O ₂ (%)	<input style="width: 90%;" type="text"/>
Islet Number	<input style="width: 90%;" type="text"/>
Islet Equivalents, IEQ	<input style="width: 90%;" type="text"/>
Islet Purity (%)	<input style="width: 90%;" type="text"/>
Time of IEQ Count	<input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx

— Pre Transplant Islet Viability Tests —

Test Methods	<input style="width: 90%;" type="text"/>
Test Results	<input style="width: 90%;" type="text"/>

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DONOR FORM FOR CLINICAL ISLET TRANSPLANTS (FETAL TISSUE)

— INSTITUTION AND RECIPIENT IDENTIFICATION —

Institution #	Transplant Center	Case #	Local Code	Date of Tx
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

— DONOR DATA —

Refer to Donor #	<input style="width: 90%;" type="text"/>
Gestational Age (wks)	<input style="width: 90%;" type="text"/>
Sex	<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> female
ABO	<input type="checkbox"/> 0 <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> 0 <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> 0 <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> 0 <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> 0 <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB <input type="checkbox"/> 0 <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> AB
HLA: A	<input style="width: 90%;" type="text"/>
B	<input style="width: 90%;" type="text"/>
DR	<input style="width: 90%;" type="text"/>
DQ	<input style="width: 90%;" type="text"/>
Crossmatch	<input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg.
CMV	<input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg. <input type="checkbox"/> pos. <input type="checkbox"/> ND <input type="checkbox"/> neg.

— Pancreas Procurement and Preservation —

Method of Abortion	<input type="checkbox"/> Hysterotomy <input type="checkbox"/> Curettage <input type="checkbox"/> PG E2 <input type="checkbox"/> Water Bag <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Curettage <input type="checkbox"/> PG E2 <input type="checkbox"/> Water Bag <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Curettage <input type="checkbox"/> PG E2 <input type="checkbox"/> Water Bag <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Curettage <input type="checkbox"/> PG E2 <input type="checkbox"/> Water Bag <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Curettage <input type="checkbox"/> PG E2 <input type="checkbox"/> Water Bag <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Curettage <input type="checkbox"/> PG E2 <input type="checkbox"/> Water Bag
Warm Ischemia (min)	<input style="width: 90%;" type="text"/>
Cold Ischemia (min)	<input style="width: 90%;" type="text"/>
Storage Solution	<input style="width: 90%;" type="text"/>

— Islet Graft Preparation —

Pretreatment	<input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres. <input type="checkbox"/> Fresh <input type="checkbox"/> Culture <input type="checkbox"/> Cryopres.
If Cultured: Days	<input style="width: 90%;" type="text"/>
Temp (°C)	<input style="width: 90%;" type="text"/>
O ₂ (%)	<input style="width: 90%;" type="text"/>
Graft Volume	<input style="width: 90%;" type="text"/>
Volume Determination	<input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx <input type="checkbox"/> pre cult/cryo <input type="checkbox"/> pre tx

— Pre Transplant Islet Viability Tests —

Test Methods	<input style="width: 90%;" type="text"/>
Test Results	<input style="width: 90%;" type="text"/>

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FOLLOW-UP FORM FOR CLINICAL ISLET TRANSPLANTS

— INSTITUTION AND RECIPIENT IDENTIFICATION —

Institution #	Transplant Center	Case #	Local Code	Date of Tx
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

— PATIENT STATUS —

Patient Status	Date	If not alive, give cause of death (related to islet tx?)
<input type="checkbox"/> Alive <input type="checkbox"/> Dead	<input type="text"/>	<input type="text"/>

— GRAFT FUNCTION AND IMMUNOSUPPRESSION —

	Insulin U/day	basal (fasting)		stimulated		Sustacal Stimulation Index	HbA1c %	Crea mg/dL μmol/L	Prednisone mg/day
		C-Peptide ng/mL pmol/mL	Glucose mg/dL mmol/L	C-Peptide ng/mL pmol/mL	Glucose mg/dL mmol/L				
PreTx	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1 wk	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1 mo	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 mo	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6 mo	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1 yr	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 yrs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 yrs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4 yrs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5 yrs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please make sure that C-Peptide and Glucose Levels are corresponding,
i.e. taken from the same sample or at least drawn at the same time !!

Off Insulin	<input type="text"/>	Maintenance	<input type="checkbox"/> None
Resumed Insulin	<input type="text"/>	Immunosuppression	<input type="checkbox"/> Steroids
Islets Failed	<input type="text"/>		<input type="checkbox"/> CsA
Cause of Graft Failure	<input type="checkbox"/> Primary Nonfunction	<input type="checkbox"/> Death of Patient	<input type="checkbox"/> AZA
	<input type="checkbox"/> Rejection	<input type="checkbox"/> Unknown	<input type="checkbox"/> FK 506
	<input type="checkbox"/> Insuff. Islet Mass	<input type="checkbox"/> _____	<input type="checkbox"/>

— REJECTION EPISODES —

	Date	Anti-Rejection Therapy	Organ Funct. after Rej. Epi.
Islets: none until	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Failed
1st	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Failed
2nd	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Failed
Kidney: none until	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Failed
1st	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Failed
2nd	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Failed
3rd	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Failed

— COMMENTS / COMPLICATIONS —

<input type="text"/>	Last Date of Completion
<input type="text"/>	<input type="text"/>