Transplant-Transmitted Infections

Organism/Disease involved (if unknown illness write 'unknown'):					
Organism/Disease identified in: ☐ Donor ☐ Recipient			DATE ____/____/________		
Health Department ID# (if applicable)					
OPO Information /Donor Information					
UNOS ID # __ __ __ __ __ __					
OPO Name:	Contact Name:				
City: State:	Office Phone:	Cell Phone:			
	E-mail address:				
Donor Hospital:	Contact Name:				
City: State:	Office Phone:	Cell Phone:			
	E-mail address:				
Donor Demographics					
Last Name:	First Name:	MI:			
Address:					
City:	County:	State:	Zip:		
Phone:	Alternate Phone:				
Date of Birth: __ __ / __ __ / __ __ __ __	Age: _________ ☐ Days ☐ Months ☐ Years				
SEX: ☐ Male ☐ Female	RACE: ☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Black/African American ☐ White ☐ Other ☐ Unknown	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown			

Donor Diagnostic Test(s) used to detect Organism/Disease:

Collection Date	Test Date	Specimen (plasma, serum, whole blood, other)	Test Type	Test Result	Testing Facility (name, city, state)

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Brief description of event (How was disease diagnosed or organism identified):

Date Organs Recovered: __/__/____

Check organs recovered	Transplanted?		Transplant Center Notified?	
☐ Heart	☐ YES	☐ NO	☐ YES	☐ NO
☐ Right Lung	☐ YES	☐ NO	☐ YES	☐ NO
☐ Left Lung	☐ YES	☐ NO	☐ YES	☐ NO
☐ Liver	☐ YES	☐ NO	☐ YES	☐ NO
☐ Intestines	☐ YES	☐ NO	☐ YES	☐ NO
☐ Pancreas ☐ Whole ☐ Islet cells	☐ YES	☐ NO	☐ YES	☐ NO
☐ Right Kidney	☐ YES	☐ NO	☐ YES	☐ NO
☐ Left Kidney	☐ YES	☐ NO	☐ YES	☐ NO
☐ Vessel Conduits	☐ YES	☐ NO	☐ YES	☐ NO

Was an autopsy performed?	☐ YES	☐ NO
Are donor specimens available for testing?	☐ YES	☐ NO
If yes, were blood products/fluids given in 24 hours prior to sample collection?	☐ YES	☐ NO
If yes, results of hemodilution calculations	☐ Suitable ☐ Not Done	☐ Unsuitable

Specimens at OPO

Serum	☐ YES	☐ NO	Quantity: ____________mls
Plasma	☐ YES	☐ NO	Quantity: ____________mls
Tissues	☐ YES	☐ NO	List:

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Specimens at Donor Hospital or Transplant centers		
Serum List Center and Contact:	☐ YES ☐ NO	Quantity: ____________mls
Plasma List Center and Contact:	☐ YES ☐ NO	Quantity: ____________mls
Tissues List Center and Contact:	☐ YES ☐ NO	List:

Were tissues procured with organs ☐ YES ☐ NO If YES, obtain information on tissue status		
Tissue Bank Name:	Contact Name:	
	Office Phone:	Cell Phone:
	E-mail address:	
Eye Bank Name:	Contact Name:	
	Office Phone:	Cell Phone:
	E-mail address:	

Specimens from Autopsy List Contact for Specimens:		
Serum	☐ YES ☐ NO	Quantity: ____________mls
Plasma	☐ YES ☐ NO	Quantity: ____________mls
Tissues	☐ YES ☐ NO	List:

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Transplant Recipient Hospital(s) Information

Use separate page for each transplanted organ into different recipient. The same page can be used for multi-organ transplant (i.e., double lung, kidney/pancreas) into same recipient.

Organ Transplanted: ☐ Heart ☐Right Lung ☐ Left Lung ☐ Liver ☐ Intestines

☐ Pancreas ☐ Right Kidney ☐ Left Kidney ☐ Vessel Conduits

Transplant Hospital: State: City:	Contact Name:	
	Office Phone:	Cell Phone:
	E-mail address:	

Recipient Demographics

Last Name:	First Name:	MI:	
Address:			
City:	County:	State:	Zip:

Phone:	Alternate Phone:
Date of Birth: __ __ / __ __ / __ __ __ __	Age: _________ ☐ Days ☐ Months ☐ Years

SEX:	RACE:	Ethnicity:
☐ Male ☐ Female	☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Black/African American ☐ White ☐ Other ☐ Unknown	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Does organ recipient have laboratory or clinical evidence consistent with implicated disease?	☐ YES ☐ NO

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IF YES, describe clinic presentation

Recipient Diagnostic Testing (For additional test results, use additional sheets.)

Date of Collection	Date of Test	Specimen (serum, whole blood, other)	Test Type	Test Result	Testing Facility (name, city, state)

Did organ recipient receive blood products? *If YES, may need to investigate blood as possible source of infection*	☐ YES ☐ NO

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