# ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
# ORGAN TRANSPLANTATION FORM

**Form Completion Instructions:**

This form should be completed at the time a patient is being considered for a transplant. It should be completed or updated once the patient has received a transplant.

# ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
## Organ Transplantation Form

**This form should be completed at the time the patient is being considered for an organ transplant. It should also be completed once the patient has received a transplant. Please identify the location of the transplant center in the space provided.**

1. Date form completed: F20Q01_fzd (fuzzed) ___ ___/ ___ ___/ ___ ___ (month / day / year)
2. Patient Registry ID: newID (scrambled) ___ ___ ___ ___ ___
3. Patient name code: namecode (censored) ___ ___ ___ ___
4. Clinical Center code number: clinic (censored) ___ ___

### AWAITING TRANSPLANTATION

5. Is patient on a "transplant list"?: F20Q05 ___(1)Yes ___(2)No
   If YES, answer Questions 6a-b. If NO, skip to Question 6:
   a. For what organ is patient listed?: F20Q05A
      ___(1)Lung ___(3)Heart/Lung
      ___(2)Liver ___(4)Other (specify): F20Q05AS
   b. Date placed on list: F20Q05B_fzd (fuzzed) ___ ___/ ___ ___/ ___ ___ (month / day / year)

### RECEIVED TRANSPLANT

6. Was patient transplanted?: F20Q06 ___(1)Yes ___(2)No
   If NO, skip to end of form. If YES, answer Questions 6a-d:
   a. Date of transplant: F20Q06A_fzd (fuzzed) ___ ___/ ___ ___/ ___ ___ (month / day / year)
   b. What organ was transplanted?: F20Q06B
      ___(1)Lung ___(3)Heart/Lung
      ___(2)Liver ___(4)Other (specify): F20Q06BS
   c. Type of lung transplant? F20Q06C ___(1)Unilateral ___(2)Bilateral
   d. Was patient transplanted at the center identified below? F20Q06D (1)Yes ___(2)No
      If NO, specify location of transplant center in comments section.

7. Did patient require another transplant?: F20Q07 ___(1)Yes ___(2)No
   If NO, skip to end of form. If YES, answer Questions 7a-d:
   a. Date of transplant: F20Q07A_fzd (fuzzed) ___ ___/ ___ ___/ ___ ___ (month / day / year)
   b. What organ was transplanted?: F20Q07B
      ___(1)Lung ___(3)Heart/Lung
      ___(2)Liver ___(4)Other (specify): F20Q07BS

*White: Clinical Coordinating Center, Pink: Clinical Center*

Patient Registry ID: ___ ___ ___ ___ ___
DFC: ___ ___/ ___ ___/ ___ ___
month day year

c. Type of lung transplant? F20Q07C ___(1)Unilateral ___(2)Bilateral

d. Was patient retransplanted at the center identified below? F20Q07D ___(1)Yes ___(2)No
If NO, specify location of transplant center in comments section.

**Transplantation Center Information:**

8. Tx Center Name: F20Q08 (censored)
9. Tx Center Address: F20Q091 (censored)
F20Q092 (censored)

10. Tx Physician's Name: F20Q10 (censored)

Comments: comment1 (censored)
comment2 (censored)

Form Completed by: comp_by (censored)

*White: Clinical Coordinating Center, Pink: Clinical Center*