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