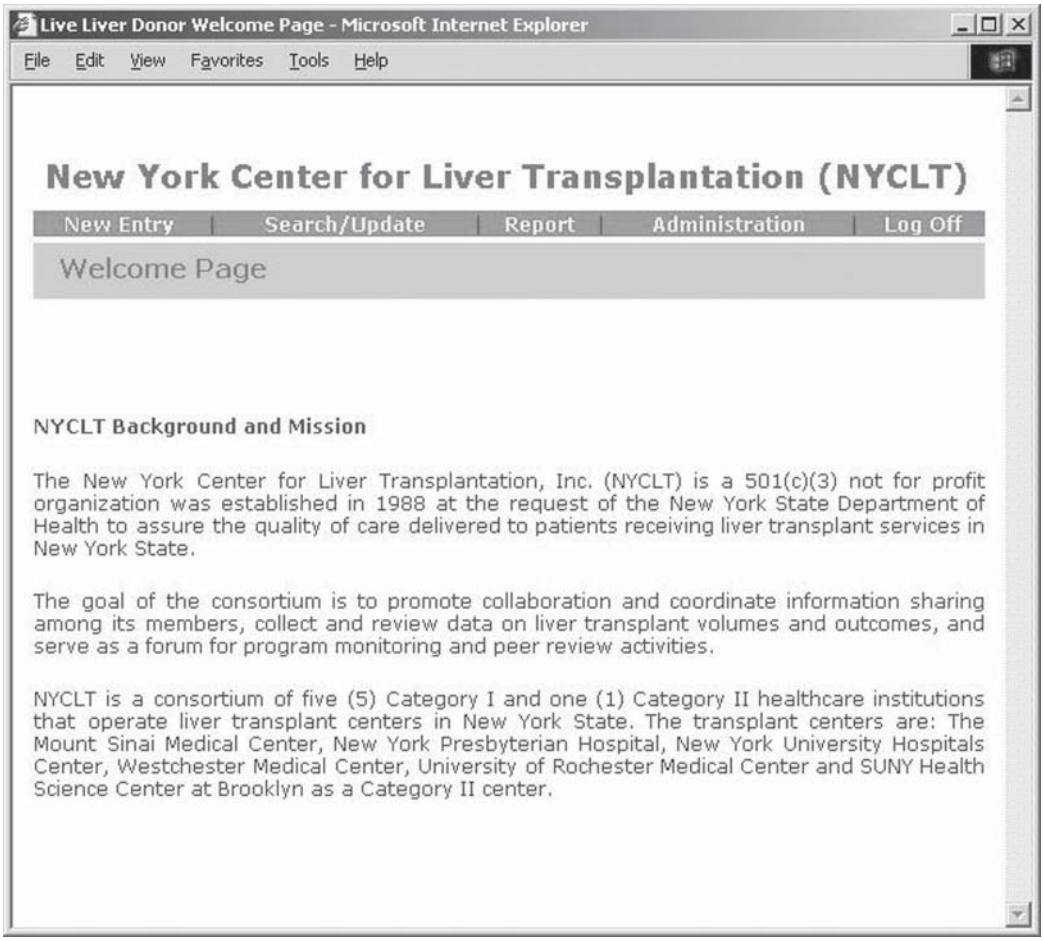
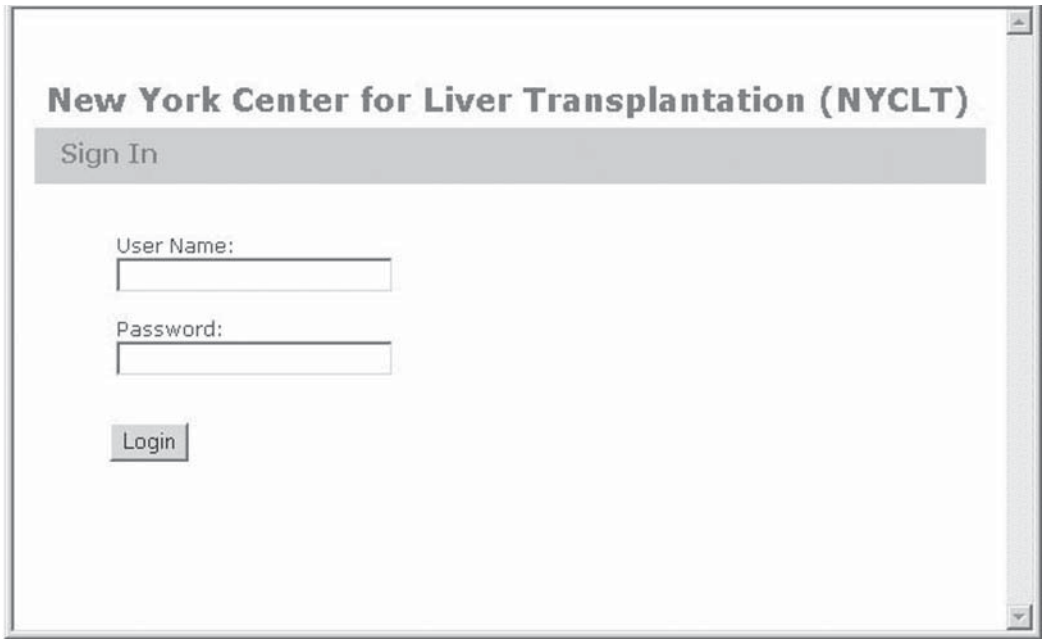
NYCLT Online Data Collection Instrument





Provider Information

Provider Information

Assessment Time Frame Post Surgery

Discharge / 6 Weeks

Date of Assessment

(mm/dd/yyyy)

Donor Information

Donor Social Security Number

- -

UNOS Identifier

Hospital ID Number

New Donor / New Survey

Provider Information

Provider Information

Assessment Time Frame Post Surgery

Discharge / 6 Weeks

Date of Assessment

12/04/2002

Donor Information

Donor Social Security Number

123 - 45 - 6789

UNOS Identifier

Hospital ID Number

Donor Demographics

Donor Gender

○ Male ○ Female

Date of Birth

(mm/dd/yyyy)

Is Donor Related to Recipient?

○ Yes ○ No

Does Donor Have Health Insurance?

○ Yes ○ No

Surgery Information

Date of Hepatectomy

(mm/dd/yyyy)

Was Procedure Aborted After Donor Received Anesthesia?

○ Yes ○ No

If Yes, Please Indicate Reason?

- ☐ Cardiac Issues
- ☐ Anesthesia Issues
- ☐ Donor Anatomy Issues
- ☐ Recipient Issues
- ☐ Other :

Did Donor Experience Any Vascular Complications Requiring Intervention?

○ Yes ○ No

If Yes, Please Indicate Type(s) of Vascular Complication

- ☐ Portal Vein
- ☐ Hepatic Vein
- ☐ Hepatic Artery
- ☐ Pulmonary Embolus Requiring Anticoagulation or Filter
- ☐ Deep Vein Thrombosis Requiring Anticoagulation or Filter
- ☐ Other : [ ]

Did Donor Receive Any Non-Autologous Blood Transfusions?

○ Yes ○ No

If Yes, Please Indicate Number of PRBC Units Donor Received

[ ]

Did Donor Experience Any Other Complications Requiring Intervention?

○ Yes ○ No

If Yes, Please Indicate Type of Complication

- ☐ Ascites Requiring Treatment
- ☐ Line or IV Complication Requiring IV Antibiotics or Intervention
- ☐ Pulmonary (Pneumonia Requiring Antibiotics/Reintubation/Pleural Effusion Requiring Therapy)
- ☐ Wound Complication (Infection Requiring Antibiotics or Other Intervention)
- ☐ Brachial Nerve Injury
- ☐ Other : [ ]

Did Donor Have to Have a Re-Operation?

○ Yes ○ No

If Yes, Please Indicate Type of Operation and Associated Date

- ☐ Liver Failure Requiring Transplant Date (mm/dd/yyyy)
- ☐ Bleeding Date (mm/dd/yyyy)
- ☐ Biliary Date (mm/dd/yyyy)
- ☐ Hernia Repair Date (mm/dd/yyyy)
- ☐ Bowel Obstruction Date (mm/dd/yyyy)
- ☐ Vascular Date (mm/dd/yyyy)
- ☐ Other : Date (mm/dd/yyyy)

Was Donor Readmitted to Hospital After Initial Discharge?

○ Yes ○ No

If Yes, Indicate Reason and Date of Readmission

- ☐ Wound Infection Date (mm/dd/yyyy)
- ☐ Fever Date (mm/dd/yyyy)
- ☐ Bowel Obstruction Date (mm/dd/yyyy)
- ☐ Pleural Effusion Date (mm/dd/yyyy)
- ☐ Dehydration Date (mm/dd/yyyy)
- ☐ Ileus Date (mm/dd/yyyy)
- ☐ Dehiscence Date (mm/dd/yyyy)
- ☐ Portal Vein Thrombosis Date (mm/dd/yyyy)
- ☐ Intrabdominal Adcess Date (mm/dd/yyyy)
- ☐ Other : Date (mm/dd/yyyy)

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- ☐ Hepatic Vein
- ☐ Hepatic Artery
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- ☐ Bleeding — Date (mm/dd/yyyy)
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- ☐ Bowel Obstruction — Date (mm/dd/yyyy)
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- ☐ Dehydration — Date (mm/dd/yyyy)
- ☐ Ileus — Date (mm/dd/yyyy)
- ☐ Dehiscence — Date (mm/dd/yyyy)
- ☐ Portal Vein Thrombosis — Date (mm/dd/yyyy)
- ☐ Intrabdominal Adcess — Date (mm/dd/yyyy)
- ☐ Other : _____ — Date (mm/dd/yyyy)

Did Donor Have Any Other Interventional Procedures?

○ Yes ○ No

If Yes, Please Indicate Type and Date(s) of Intervention Procedure

1. [ ] Date (mm/dd/yyyy) [ ]
2. [ ] Date (mm/dd/yyyy) [ ]

Mortality

Mortality?

○ Yes ○ No

If Yes, Indicate Cause and Date of Donor Death.

[ ] 30 (chars left)

Date (mm/dd/yyyy) [ ]

Did Donor Have Any Other Interventional Procedures?

○ Yes ○ No

If Yes, Please Indicate Type and Date(s) of Intervention Procedure

1. [ ] Date (mm/dd/yyyy) [ ]
2. [ ] Date (mm/dd/yyyy) [ ]

Return to Work

Did Donor Return to Work?

- ☐ Full Time — Date (mm/dd/yyyy) [ ]
- ☐ Part Time — Date (mm/dd/yyyy) [ ]
- ☐ Homemaker — Date (mm/dd/yyyy) [ ]
- ☐ Unemployed, Seeking Work — Date (mm/dd/yyyy) [ ]
- ☐ Retired — Date (mm/dd/yyyy) [ ]
- ☐ Disabled — Date (mm/dd/yyyy) [ ]

Mortality

Mortality?

○ Yes ○ No

If Yes, Indicate Cause and Date of Donor Death.

[ ] 30 (chars left)

Date (mm/dd/yyyy) [ ]