Please fax or mail to: FAP-World Transplant Register, Department of Transplantation Surgery F82, Karolinska University Hospital Huddinge, S-141 86 Stockholm, Sweden. Fax nr +46 8 774 31 91 **E-mail: fapwtr@fapwtr.org Web site: www.fapwtr.org**

Domino/Sequential Transplantation (DLTX)

FORM 2 – UPDATE

(Please use one page for each patient)

Name and location of Tx center:_____

Date of report ___ ___ ___
D M Y

Contact person & title:_____

Register use only

FAPWTR: M ☐

DRnr: A ☐

Pat id ___ ___ ___ (Given name) first letters ___ ___ ___ (Family name) first letters Born ___ ___ ___ D M Y

Date of DLTX ___ ___ ___ D M Y **Recurrence of tumor:** Yes ☐ No ☐ If yes, approx date: ___ ___ ___ D M Y

Recurrence of original disease other than tumor: Yes ☐ No ☐ If yes, approx date: ___ ___ ___ D M Y

Re- LTX: Yes ☐ No ☐ Date: ___ ___ ___ D M Y Cause of re-LTX:_____

Domino re-LTX: Yes ☐ No ☐

Alive? Yes ☐ No ☐ Date of death ___ ___ ___ D M Y Cause of death:_____

MBMI: Height:_____ m Weight:_____ kg Serum albumin:_____ units (Ref.value:_____)

IF FAP DONOR: POST TRANSPLANT ONSET OF

	Yes	No	Approx. date: (D – M – Y)
PERIPHERAL NEUROPATHY			
* sensory……..	☐	☐	_____
* motor…….	☐	☐	_____
AUTONOMIC NEUROPATHY			
* digestive……..	☐	☐	_____
* urinary…….	☐	☐	_____
* sexual dysfunction……..	☐	☐	_____
* cardiovascular…….	☐	☐	_____
EXTRANEUROLOGIC AMYLOIDOSIS			
* renal……	☐	☐	_____
* ocular……..	☐	☐	_____
* cardiac……	☐	☐	_____
PSYCHIATRIC DISTURBANCES	☐	☐	_____

IF NON-FAP DONOR: POST TRANSPLANT SYMPTOMS OF DONOR DISEASE

Yes ☐ No ☐

If Yes Approx date (D – M – Y)
_____

COMMENTS: