



HEART VALVE RECIPIENT REGISTRATION FORM

Centre		Telephone number	
Physician		Contact to	

RECIPIENT

Name		Date of birth		M/F
Initials				

STRUCTURE AFFECTED

PREVIOUS REPLACEMENT

<input type="radio"/> Aortic valve	<input type="radio"/> Pulmonary valve	<input type="radio"/> Aorto-iliac bifurcation	<input type="radio"/> None	<input type="radio"/> Allograft
<input type="radio"/> Aorta arch	<input type="radio"/> Pulmonary artery	<input type="radio"/> Arteries	<input type="radio"/> Artificial graft	<input type="radio"/> Xenograft

Other:

NYHA Class	<input type="checkbox"/> I	<input type="checkbox"/> IIA	<input type="checkbox"/> IIB	<input type="checkbox"/> III	<input type="checkbox"/> IV
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TYPE OF DYSFUNCTION

<input type="radio"/> Atresia	<input type="radio"/> Defect	<input type="radio"/> Hypoplasia	<input type="radio"/> Insufficiency	<input type="radio"/> Paravalvular leakage
<input type="radio"/> Aneurysm	<input type="radio"/> Degeneration	<input type="radio"/> Infection	<input type="radio"/> Stenosis	

Other:

UNDERLYING DISEASE

<input type="radio"/> Active endocarditis	<input type="radio"/> s/p endocarditis	<input type="radio"/> hypoplastic left heart	<input type="radio"/> hypoplastic right heart	<input type="radio"/> Truncus arteriosus communis
<input type="radio"/> Tetralogy of Fallot	<input type="radio"/> valve anomalia	<input type="radio"/> Non valvular anomalia	<input type="radio"/> Coarctatio interruptio aortae	<input type="radio"/> Transposition greater arteries

Other

REQUIRED GRAFT

<input type="radio"/> Aortic valve	<input type="radio"/> Pulmonary valve	<input type="radio"/> Aortic or Pulmonary valve	<input type="radio"/> Aortoiliac bifurcation	<input type="radio"/> Thoracic Aorta
<input type="radio"/> Aortic patch	<input type="radio"/> Pulmonary patch	<input type="radio"/> Aortic and Pulmonary valve	<input type="radio"/> Iliac femoral artery	

Diameter range (mm)		Minimal length (mm)		Bifurcation/Arch	YES	NO
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Operation date		Remarks:
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The undersigned (Medical Doctor), declares that the above-mentioned patient agrees to provide the requested data to ETB-BISLIFE for the purpose of registration as a possible graft recipient and to match these data against the data of available grafts. Furthermore, the undersigned declares that the patient has given permission for use of transplantation data, as far as necessary to optimize the mediation services of ETB-BISLIFE

Date:

Name of MD:

Signature: