



Heart valve recipient registration form

TS.HV.FOR.001 | Versiedatum: 18/01/2018

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email:
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Registration number : _____

Registration date : _____

Centre	Telephone No
City / Country	Fax No
Phys. in charge	Contact to

Last Name	Date of birth
Prefix	M / F
Initials	Country

NYHA classification at registration	<input type="radio"/> I	<input type="radio"/> IIA	<input type="radio"/> IIB	<input type="radio"/> III	<input type="radio"/> IV
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Structure affected (more items possible)				Previous replacement	
<input type="radio"/> Aortic valve	<input type="radio"/> Mitral valve	<input type="radio"/> Aorto-iliac bifurcation	<input type="radio"/> Iliac arteries	<input type="radio"/> None	
<input type="radio"/> Femoral arteries	<input type="radio"/> Pulmonary valve	<input type="radio"/> Aorta ascendens	<input type="radio"/> Aorta descendens	<input type="radio"/> Allograft	
<input type="radio"/> Aorta arch	<input type="radio"/> Pulmonary artery	<input type="radio"/> Septum AS	<input type="radio"/> Septum VS	<input type="radio"/> Xenograft	
<input type="radio"/> Other*				<input type="radio"/> Artificial graft	
				<input type="radio"/> Autograft	

Type of dysfunction (more items possible)				
<input type="radio"/> Insufficiency	<input type="radio"/> Stenosis	<input type="radio"/> Atresia	<input type="radio"/> Hypoplasia	<input type="radio"/> Paravalvular leakage
<input type="radio"/> Aneurysm	<input type="radio"/> Defect	<input type="radio"/> Degeneration	<input type="radio"/> Infection	<input type="radio"/> Other*

Underlying disease (more items possible)			
<input type="radio"/> Active endocarditis	<input type="radio"/> S/p endocarditis	<input type="radio"/> S/p rheumatoid fever	<input type="radio"/> S/p previous surgery
<input type="radio"/> Valve anomalia	<input type="radio"/> Non valvular anomalia	<input type="radio"/> Tetralogy of Fallot	
<input type="radio"/> Hypoplastic left heart	<input type="radio"/> Truncus arteriosus communis	<input type="radio"/> Coarctatio / interruptio aortae	
<input type="radio"/> Transposition greater arteries	<input type="radio"/> Hypoplastic right heart	<input type="radio"/> Morbus Marfan	
<input type="radio"/> Double outlet right ventricle	<input type="radio"/> Noonans syndrome	<input type="radio"/> Down Syndrome	
<input type="radio"/> Double inlet left ventricle	<input type="radio"/> Degenerated valve	<input type="radio"/> Aortic occlusion	

DONOR REQUIREMENTS

Required allograft	<input type="radio"/> Valve	<input type="radio"/> Patch	<input type="radio"/> Thoracic Aorta	<input type="radio"/> Aorto-iliac bifurcation	<input type="radio"/> Arteries
Type required	<input type="radio"/> Aortic	<input type="radio"/> Pulmonary	<input type="radio"/> Aortic or Pulmonary		
Diameter range		(in mm)	Minimal length		(in mm)
Operation date	(dd/mm/yy) . . . / . . . /				

In case an aortic allograft is requested, do you need an arch? No Yes

In case a pulmonary allograft is requested, do you need a bifurcation ? No Yes

If Yes, please note that this will limit the options for selection. For a longer graft, only fill in the minimal length above

Specification of * / remarks

The undersigned, in the function of medical doctor, declares that his/her above mentioned patient agrees to provide the above mentioned data to ETB-BISLIFE for the purpose of his/her registration as a possible



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transplant recipient and to match these data against the data of a possible donor. The undersigned furthermore declares that his/her patient has given permission to use the data that will become available after transplantation, as far they are required to optimize the sharing program of ETBBISLIFE.

Date (dd/mm/yy)	. . . / . . . /	Name of MD	Signature MD
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In order to register your patient on the waitinglist: complete this form and return it to ETB-BISLIFE