Cause of Death Form (CRF)

Patient ID: ____
Date of death: ____

Section 1 Background, clinical and demographics

A. Date of birth: B. Gender: male female

C. Transplant date: D. Transplant type:

E. Primary disease:

Section 2 Risk factors (please mark all that apply)

A. Ongoing risk factors in the year prior to death:

1. Cigarette smoking	___Yes	___No	__Unknown
2. Excessive alcohol consumption	___Yes	___No	__Unknown
3. Active illicit injecting drug use	___Yes	___No	__Unknown
4. Active illicit non-injecting drug use	___Yes	___No	__Unknown
5. Opiate substitution	___Yes	___No	__Unknown

Section 3 Co-morbidities (please mark all that apply)

A. Ongoing chronic conditions:

1. DM	___Yes	___No	__Unknown
2. Hypertension	___Yes	___No	__Unknown
3. Dyslipidemia	___Yes	___No	__Unknown

B. Prior cardiovascular disease ___Yes ___No __Unknown

If yes, please specify disease: _____

C. Prior peripheral arterial disease ___Yes ___No __Unknown

If yes, please specify disease: _____

D. Prior cerebrovascular disease ___Yes ___No __Unknown

If yes, please specify disease: _____

E. COLD ___Yes ___No __Unknown

F. Connective tissue disease ___Yes ___No __Unknown

If yes, please specify disease: _____

G. Liver disease ___Yes ___No __Unknown

If yes, please specify disease: _____

H. Kidney disease ___Yes ___No __Unknown

If yes, please specify disease: _____

I. Malignant disease ___Yes ___No __Unknown

If yes, please specify disease: _____

J. HIV ___Yes ___No __Unknown

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Section 4 Cause of death

A. Was the death sudden? ___Yes ___No ___Unknown

B. Was the death unexpected? ___Yes ___No ___Unknown

C. Please complete the table below by recording all illnesses and conditions (acute and chronic) or injuries that the patient had at time of death

	Illness / Condition / Injury (text)	**Date of onset**	**Certainty of diagnosis***		
			Definite	Likely	Possible
1					
2					
3					
4					
5					
6					
7					
8					
9					

***Certainty of Diagnosis: Definite**=95-100% certainty, **Likely**=80-95% certainty**, Possible**=50-80% certainty

D. Brief narrative of the sequence of events leading to death (please include means of diagnosis of illnesses):

_____

_____

_____

_____

_____

_____

_____

_____

E. Summary of causal relations between conditions leading to death (specific causes of death can be chosen from a drop-down menu including 267 individual causes):

1. Condition that directly caused the death (immediate cause of death):_____
2. Due to, or as a consequence of: _____
3. Due to, or as a consequence of: _____
4. Due to, or as a consequence of (the underlying cause of death): _____

Comment (does not have to be filled): _____

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Section 5 Post-mortem / Autopsy

A. Has autopsy been performed: ___Yes ___No Unknown Save

Should the autopsy report be available from Patobank, the conclusion of the report can be automatically attached to this section by clicking the "save" button.

Section 6 Graft information

A. Graft compatibility:

ABO identical	___Yes	___No	__Unknown	__not relevant
ABO compatible	___Yes	___No	__Unknown	__not relevant
Pre-transplant donor specific antibody	___Yes	___No	__Unknown	__not relevant
HLA ABC 10/10 match	___Yes	___No	__Unknown	__not relevant
DRB1 match	___Yes	___No	__Unknown	__not relevant
DQB1 match	___Yes	___No	__Unknown	__not relevant

B. Was the graft functioning consistently up to the time of death?

(acute organ failure as a consequence of the terminal illness is not to be included)

___Yes ___No __Unknown __not relevant

If no, has the graft been removed? (Relevant for kidney transplants only**)**

___Yes ___No __Unknown __not relevant

If yes, date:

C. Was there graft-versus-host disease at time of death? (Relevant for HCT patients only)

___Yes ___No __Unknown __not relevant

D. Was there complete remission of the cancer that resulted in the transplantation, at time of death?

(Relevant for cancer patients only)

___Yes ___No __Unknown __not relevant

Section 7 Concomitant infections

A. Were there any concomitant infections identified in the month up to the time of death?

___Yes ___No __Unknown

If yes, please provide details:

Microbial agent: (can be chosen from a drop-down menu including 92 microbial agents or written in a free text field)	**Sample material** (can be chosen from a drop-down menu including 7 types of sampling or written in a free text field)	**Date of first identification**

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B. Was there given any anti-microbial therapy?

___Yes ___No __Unknown

If yes, please specify which one(s):

Antimicrobial therapy: (can be chosen from a drop-down menu including 30 different therapies or written in a free text field)	**Alternative:** (free text field)

C. Was there resistance to any anti-microbial therapy?

_____Yes _____No Unknown

If yes, please specify which one(s)?

Antimicrobial therapy: (can be chosen from a drop-down menu including 30 different therapies or written in a free text field)	**Alternative:** (free text field)

Section 8 **Laboratory values latest prior to death** (this section is automatically filled out upon completion of CRF)

Sampling date	**Results date**	**Laboratory values**		**Material**	**Value**	**Unit**	**Result Lab.**	**Ref. ID**
		Hemoglobin						
		Creatinine						
		ALT						
		Bilirubine						
		INR						
		Neutrocytes						

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Section 9 Adverse reactions of any type to the medical treatment:

A. Was the death considered to be related to a medical treatment?

___Yes ___No Unknown

If yes, please specify which one(s)?

Immunosuppressive therapy: (free text field)	**Date of first initiation**	**Certainty of relationship to drug***		
		Definite	Likely	Possible
Other medication: (free text field)				

*__Definite__ (95-100% certainty); __Likely__ (80-95%); __Possible__ (50-80%)Please provide a

Please provide a brief narrative of the suspected association

_____
_____
_____
_____