Stanford Integrated Psychosocial Assessment for Transplant (SIPAT)
Stanford University Medical Center
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Patient’s Name: ___________________________ Date: ____________

Patient’s MR#: __________________________________________ Total Score: __________

SIPAT Examiner: _______________________________________

A. PATIENT’S READINESS LEVEL

I. Knowledge & Understanding of Medical Illness Process (that caused specific organ failure)
   0) Excellent Understanding: High degree of self-directed learning and excellent knowledge of treatment risks & benefits.
   1) Good Understanding: Patient & support system are fully aware of the cause of illness & contribution to current health status.
   2) Moderate Understanding: Patient has modest knowledge despite teaching/material provided.
   3) Limited Understanding: Patient only has rudimentary knowledge despite years of illness & extensive teaching by providers.
   4) Poor Understanding: Extreme denial or indifference evident.

II. Knowledge & Understanding of the Process of Transplantation
   0) Excellent Understanding: High degree of self-directed learning and excellent knowledge of treatment risks & benefits.
   1) Good Understanding: Patient & support have studied & understood provided literature – Or – A patient who just found out about his/her condition and no education has been provided.
   2) Moderate Understanding: Patient has modest knowledge despite teaching/material provided.
   3) Limited Understanding: Patient only has rudimentary knowledge despite of intensive teaching by providers.
   4) Poor Understanding: Extreme denial or indifference evident.

III. Willingness/Desire for Treatment (Transplant)
   0) Excellent: Patient highly motivated & directly involved in his/her medical care.
   1) Good: Patient expresses interest but actions only acceptable at best.
   2) Moderate: Patient appears ambivalent; only passively involved in process.
   3) Limited: Family member or MD more interested in Transplant process than patient.
   4) Poor: Family member or MD pushing patient to participate in the Transplantation evaluation process.

IV. Treatment Compliance/Adherence (Pertinent to medical issues)
   0) Excellent: Full compliance & effective self-management.
   2) Good: Patient may be challenging, but fully compliant.
   4) Moderate: Only partial compliance, requires multiple efforts and persuasion from the Transplant team and/or family.
   6) Limited: Only compliant after the development of complications.
   8) Poor: Evidence of significant treatment non-adherence with negative impact in patient’s health (i.e., Treatment non-adherence/compliance; continued substance use after learning of illness).

V. Lifestyle Factors (Including diet, exercise, fluid restrictions; and habits according to organ)
   0) Able to modify & sustained needed changes- self initiated.
   1) Patient is reluctant but compliant with recommended changes.
   2) Patient complies with recommended changes only after much prompting and encouragement from support & Transplant team.
   3) Patient complies with recommended changes only after the development of complications.
   4) Unhealthy diet & sedentary lifestyle. Reluctant to change. (i.e., non-adherence with recommended restrictions; continued substance use after learning of illness).

Score P1: _____
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B. SOCIAL SUPPORT SYSTEM

VI. Availability of Social Support System
0) Excellent: Several family, significant others &/OR friends have been identified and are actively engaged as part of the support system. Excellent back-up system in place.
2) Good: Only one support person has been identified & appears engaged. A back-up system has not been confirmed.
4) Moderate: The patient’s identified support system appears unreliable or inconsistent. No reasonable backup system identified.
6) Limited: Patient identified support system, but support person appear conflicted, uncertain or uncommitted. No reasonable backup system identified.
8) Poor: Patient unable to identify reliable support system, or identified caregiver has failed to present to clinic.

VII. Functionality of Social Support System
0) Excellent: Support members have demonstrated initiative in learning & already committed to and engaged in patient’s care. They are ready to help.
2) Good: A limited support system has already committed to and has had limited engagement in the patient’s care. They may need some work before they are ready for transplantation.
4) Moderate: Patient’s identified system seems to have medical or social problems themselves which may impair their ability to reliably assist the patient.
6) Limited: Identified support system has problems which may prevent them for being appropriate –OR– identified person(s) express doubts/hesitation/conflict.
8) Poor: Patient has suffered due to unreliable support system –OR– team has not been able to effectively work with support.

VIII. Appropriateness of physical living space & environment
0) Excellent: Patient has permanent and adequate housing.
1) Good: Patient has some stable arrangement albeit not optimal.
2) Moderate: Reported arrangement is only temporary & tenuous.
3) Limited: Unable to confirm reported arrangement or perceived to be inappropriate.
4) Poor: Non-existent; Patient has no stable living arrangements –OR– lives in environment that doesn’t promote Transplant health.

C. PSYCHOLOGICAL STABILITY & PSYCHOPATHOLOGY

IX. Presence of Psychopathology (other than personality disorders & organic psychopathology)
0) None: No history of psychiatric problems
2) History of Mild Psychopathology (i.e. Adjustment disorder). Usually a self-limited problem without significant impact on functioning. No treatment needed. No History of SI/SA.
4) History of Moderate Psychopathology. Treatment has been effective, good compliance. No History of SI/SA at present; although possible or + History SI/SA in past.
6) History of severe psychopathology. Patient has needed multiple psychiatric hospitalizations in the past or History of SI/SA.
8) Extreme History of psychopathology present (i.e., History of multiple Psych Hosp; Treatment with ECT; History of multiple SI/SA). Patient is in need for acute psychiatric intervention before proceeding.

IXa. Assessment of Depression (Use clinical judgment; Patient Health Questionnaire [PHQ] or Beck Depression Inventory [BDI], if available)
0) No Clinical Depression; or PHQ < 5; or BDI= 0 – 13.
1) Mild Clinical Depression; or PHQ = 5 – 9; or BDI= 14 – 19.
2) Moderate Clinical Depression; or PHQ = 10 – 19; or BDI= 20 – 28.
3) Severe Clinical Depression; or PHQ ≥ 20; or BDI = 29 – 63.

IXb. Assessment of Anxiety (Use clinical judgment; Generalized Anxiety Disorder questionnaire [GAD-7] or Beck Anxiety Inventory [BAI], if available)
0) No Clinical Anxiety; or GAD-7 < 5; or BAI = 0 – 7.
1) Mild Clinical Anxiety; or GAD-7 = 5 – 9; or BAI = 8 – 15.
2) Moderate Clinical Anxiety; or GAD-7 = 10 – 14; or BAI = 16 – 25.
3) Severe Clinical Anxiety; or GAD-7 ≥ 15; or BAI = 26 – 63.  

Score P2:______
X. History of Organic Psychopathology or Neurocognitive Impairment (i.e., illness or medication induced psychopathology)

0) **None**: No history of disease or treatment induced psychiatric problem.
1) **History of Mild Organic Psychopathology**.
3) **History of Moderate Organic Psychopathology**.
5) **History of Severe Organic Psychopathology**.

Xa. Assessment of Cognitive Functioning (Use clinical judgment or use MMSE, if available)

0) **Cognitive Functioning Within Normal Limits**; or MoCA / MMSE ≥ 26.
1) **Borderline** Level of Cognitive Functioning; or MoCA / MMSE = 22 – 25.
2) **Impaired** Cognitive Functioning; or MoCA / MMSE < 22.

XI. Influence of Personality Traits vs. Disorder

0) **None**: No history of significant personality disorder or psychopathology.
1) **History of mild** personality traits or psychopathology in response to illness, medical treatment or psychosocial stressors.
2) **History of moderate** personality traits or psychopathology in response to illness, medical treatment or psychosocial stressors. Treatment, if needed, has been effective. Patient with good compliance, no characterological interference with treatment. No history of SI/SA.
3) **History of severe** personality psychopathology or traits in response to illness, medical treatment or psychosocial stressors. Patient has needed multiple psychiatric hospitalizations in the past. History of SI/SA.
4) **Extreme** character pathology present in response to illness, medical treatment or psychosocial stressors. Patient is in need for acute psychiatric intervention before proceeding.

XII. Effect of Truthfulness vs. Deceptive Behavior in Presentation

0) **No evidence** of deceptive behavior by history or at present.
2) **Patient has not volunteered some negative information, but truthfully answered direct questioning**.
4) **Patient has not been fully forthcoming with negative information, but provides it on confrontation**.
6) **Patient has not been fully forthcoming with negative information. Information obtained only from external sources**.
8) **There is clear evidence of deceptive behavior as evidence by records, collateral information or testing**.

XIII. Overall Risk for Psychopathology (including items IX – XII)

0) **None or minimal**: No history of personal or familial psychiatric problems; no psychiatric complications to illness, medical treatment or psychosocial stressors.
1) **Low**: History of acceptable coping with previous medical challenges or psychosocial stressors.
2) **Mild**: History of poor coping with previous medical challenges or psychosocial stressors.
3) **Moderate**: Patient has experienced significant psychiatric complications to medical illness, interventions or treatment –OR– Presence of moderate psychopathology in family of origin.
4) **Severe**: History of significant psychopathology present in family of origin –OR– Patient has experienced severe psychiatric complications to medical.

Score P3: _______
D. LIFESTYLE & EFFECT OF SUBSTANCE USE

XIV. Alcohol Use/Abuse/Dependence (Use clinical judgment or use AUDIT, if available)

0) **None**: No history of alcohol use. No risk: Audit = 0.

2) **ALCOHOL USE – NO ABUSE**: History of minimal alcohol use which has caused no social or medical problems (i.e., no abuse). If requested by the team the patient promptly discontinued all alcohol use. Low Risk: Audit < 7.

4) **MODERATE ALCOHOL ABUSE**: History of moderate alcohol abuse evidenced by excessive drinking and possible deleterious bodily or social effects. Pt quit use as soon as patient learned of disease or when first told by MD. Patient may have required treatment/intervention in order to achieve sobriety. Mild Risk: Audit = 8 – 15.

6) **DEPENDENCE OR SEVERE ABUSE**: History of severe alcohol abuse or dependence. Patient required treatment/intervention in order to achieve sobriety (or refused Treatment); or continued to use after disease progressed, developing medical complications. Moderate Risk: Audit = 16 – 19.

8) **DEPENDENCE OR EXTREME ABUSE**: History of extreme alcohol abuse & multiple relapses despite of warning and/or treatment. Patient continued to drink until just prior to presentation or only quit drinking when too sick to continue. High Risk: Audit > 20.

XV. Alcohol Use/Abuse/Dependence - Risk for Recidivism

0) **None**: No history of Alcohol use.

1) **Low Risk**.

2) **Moderate Risk**.

3) **High Risk**.

4) **Extreme Risk**: History of recidivism after prior treatment or after an extended period of sobriety.

XVI. Substance Use/Abuse/Dependence – Including Prescribed & Illicit Substances

(Use clinical judgment or use DAST, if available)

0) **None**: No history of illicit substance Use; or abuse of prescribed substances.

2) **History of minimal** substance abuse. Quit use as soon as patient learned of disease or when first told by MD. DAST = 1 – 2.

4) **MODERATE SUBSTANCE ABUSE**: History of moderate substance abuse, but quit use as soon as patient learned of disease or when first told by MD. Patient may have required treatment/intervention in order to achieve remission. DAST= 3 – 5.

6) **DEPENDENCE OR SEVERE ABUSE**: History of dependence or severe abuse. Patient required treatment/intervention in order to achieve sobriety (or refused treatment/intervention); or continued to use after disease progressed, developing medical complications. DAST= 6 – 8.

8) **DEPENDENCE OR EXTREME ABUSE**: History of dependence or extreme substance; History of multiple relapses despite of warning and/or treatment. Patient continued to use until just prior to presentation or only quit when too sick to continue. DAST = 9 – 10.

XVII. Substance Use/Abuse/Dependence – Including Prescribed & Illicit Substances - Risk for Recidivism

0) **None**: No history of illicit substance Use; or abuse of prescribed substances.

1) **Low Risk**.

2) **Moderate Risk**.

3) **High Risk**.

4) **Extreme Risk**: History of recidivism after prior treatment or after an extended period of sobriety.

XVIII. Nicotine Use/Abuse/Dependence

0) **None**: No history of Nicotine Use/Abuse.

1) **Quit >6 months** (‘-’ test).

3) **Quit <6 months** (‘-’ test).

5) **Still currently smoking** (per admission, accessory source report, or ‘+’ test). Score P4:______
SIPAT **TOTAL Score** (add scores for pp 1 – 4) : ______

**SIPAT Score Interpretation**

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 6</td>
<td>Excellent candidate</td>
</tr>
<tr>
<td></td>
<td>➢ Recommend to list without reservations.</td>
</tr>
<tr>
<td>7 – 20</td>
<td>Good candidate</td>
</tr>
<tr>
<td></td>
<td>➢ Recommend to list- although monitoring of identified risk factors may be required.</td>
</tr>
<tr>
<td>21 – 39</td>
<td>Minimally Acceptable Candidate</td>
</tr>
<tr>
<td></td>
<td>➢ Recommend to list under certain conditions- identified risk factors must be satisfactorily addressed before representing for consideration.</td>
</tr>
<tr>
<td>40 – 68</td>
<td>High Risk candidate, significant risks identified</td>
</tr>
<tr>
<td></td>
<td>➢ Recommend deferral while identified risks are satisfactorily addressed.</td>
</tr>
<tr>
<td>&gt; 69</td>
<td>Poor Candidate</td>
</tr>
<tr>
<td></td>
<td>➢ Surgery not recommended while identified risk factors continue to be present.</td>
</tr>
</tbody>
</table>

**Considerations for Final Psychosocial Recommendations:**

Overall numbers of Risk Factors (RF): Absolute_____ Severe_____ High_____ Moderate/Low_____

1. The patient has at least 1 absolute contraindication? Yes____ No____
   
   *If the answer to the above question is yes please refer to guidelines and consider deferment/decline. If none present proceed to next question.*

2. The patient has at least 2 high risk, relative contraindications? Yes____ No____

3. The patient has at least 3 moderate/low, relative contraindications? Yes____ No____

4. Patient failed to meet abstinence contract? Yes____ No____

5. Listed patient who failed a toxicology screening test? Yes____ No____ N/A____

6. Listed patient who is not compliant? Yes____ No____

7. The patient has active/unstable psychiatric symptoms in need of treatment or questionable psych history waiting clarification? Yes____ No____
   
   *If the answer to any question #2-7 is yes, refer to guidelines for final recommendation. If none present proceed to SIPAT interpretation.*