CONFIDENTIAL**

SINGAPORE RENAL REGISTRY

National Registry of Diseases Office
Health Promotion Board
Level 5, 3 Second Hospital Avenue
Singapore 168937
Tel: (65) 6435 3076 / 3039 or E-mail: hpb_servicenrdo@hpb.gov.sg

KIDNEY TRANSPLANT FORM

SRR No. | | | | | | | | | | |
Registry use

E-Notification: www.hpp.moh.gov.sg

1. REFERRING / TREATING HEALTHCARE INSTITUTION

Referral Clinic / Centre: _____ | | | |

Current Centre: _____ | | | |

Date of first follow-up treatment (post transplant): _____ (ddmmyyyy)

2. PARTICULARS OF PATIENT

Name*:

_____

NRIC/ Passport No/FIN/Hospital Registration No*:

Gender*: ☐ Male ☐ Female

Date of Birth*:

(ddmmyyyy)

3. DIALYSIS HISTORY

Was patient on dialysis prior to transplant: ☐ Yes ☐ No

If No, please proceed to Item 4
If Yes, please proceed to item 5

4. GLOMERULAR FILTRATION RATE (GFR) AT TIME OF TRANSPLANT

Serum Creatinine level at time of transplant: _____ umol/L / mg/dl Date: _____(dd/mm/yyyy) ☐ Missing
(The measurement of Serum Creatinine level closest to (before) the date of transplant)

eGFR: at time of transplant_____ ml/min/1.73m^2 Date: _____(dd/mm/yyyy) ☐ Missing

*Mandatory data items
** THE INFORMATION IN THE FORM NEEDS TO BE KEPT CONFIDENTIAL AFTER THE FORM HAS BEEN FILLED

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5. TRANSPLANT INFORMATION

Date of Transplant: | | | | | | | | | (ddmmyyyy)

Place where patient underwent Transplant: _____

If transplant was done Overseas, pls specify Country: _____

and Centre: _____

Graft Number : _____

6. DONOR INFORMATION

Date of Birth: | | | | | | | | | (ddmmyyyy) Age: | | |

Gender: ☐ Male ☐ Female ☐ Missing

Ethnic Group: ☐ Chinese ☐ Malay ☐ Indian ☐ Eurasian

☐ Others, specify: _____

Type I. Living Donor

Biologically related: ☐ Parents ☐ Off Spring ☐ Identical twin ☐ Sibling

☐ Others, specify: _____

Emotionally related: ☐ Spouse ☐ Friend ☐ Others, specify: _____

Neither biologically nor emotionally related: ☐ Good Samaritan ☐ Others, specify: _____

Type II. Deceased Donor ☐ Heart Beating ☐ Non-heart beating ☐ Missing

7. GRAFT STATUS

Graft Functioning ☐ Yes ☐ No

If yes,
Current Serum Creatinine level : _____ umol/L / mg/dl Date: _____(dd/mm/yyyy) ☐ Missing

eGFR: _____ ml/min/1.73m^2 Date: _____(dd/mm/yyyy) ☐ Missing

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If Graft is not functioning

Date of graft loss:: _____(dd/mm/yyyy) ☐ Missing

Cause of graft loss:

☐ Acute Rejection
☐ Hyperacute Rejection
☐ Chronic Rejection
☐ Primary non-function
☐ Recurrent disease
☐ Chronic allograft Nephropathy
☐ Graft thrombosis
☐ Ureteric obstruction
☐ Infection
☐ Other Surgical complication
☐ Non-compliance
☐ Unknown
☐ Others, specify:_____

8. DETAILS OF NOTIFYING HEALTHCARE INSTITUTION

Name of Notifying Healthcare Institution (including department)*: _____

Name of Person who made the notification: _____

Date of Notification _____ (dd/mm/yyyy)

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EXPLANATORY NOTES

CASES TO BE NOTIFIED

1. Please notify cases within 3 months after the completion of the Kidney Transplantation for Chronic Kidney Failure.

PROCEDURE FOR SUBMISSION

2. Submission may be made in the following manner:

a) by hand (including courier services)
b) by registered mail; or
c) by using such secured electronic notification system as may be approved by the Registrar.
d) Please DO NOT submit the notification form via email or fax.

NATIONAL REGISTRY OF DISEASES ACT (Chapter 201B)

(CHRONIC KIDNEY FAILURE NOTIFICATION) REGULATIONS 2011

Notification of patient who has received kidney transplant for Chronic Kidney Failure is mandatory in accordance to section 6(1) of the National Registry of Diseases Act

Please duly fill in the minimum (mandatory) data items (in asterisk) – as follow:

1. Identification number (including NRIC, passport number, Foreign Identification Number or hospital registration number)
2. Name
3. Date of birth or age (if date of birth is unknown).
4. Gender

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In pursuant to Section 7(2) of the NRD Act, you may also choose to submit information on the other items in the form or alternatively the Registry Coordinator will visit your premise to collect the additional data.

N.B. If this patient has been newly diagnosed with Kidney Failure, please complete the **Diagnosis or Commencement of Treatment of Chronic Kidney Failure notification form** together with the Kidney Transplant form to complete this notification.