# SINGAPORE RENAL REGISTRY

**YEAR-END FOLLOW-UP TREATMENT FORM**

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

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

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

## 1. TREATING HEALTHCARE INSTITUTION

Current Centre: _____ | | | |

Date treatment started at current centre: _____ (ddmmyyyy)

## 2. PARTICULARS OF PATIENT

Name*:

_____

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

| | | | | | | | | | |

Gender*: ☐ Male ☐ Female

Date of Birth*:

| | | | | | | | | (ddmmyyyy)

## 3. CO-MORBID CONDITIONS

Smoking status: ☐ Never ☐ Ex-smoker ☐ Current smoker ☐ Missing

| | | | | Date of Diagnosis (ddmmyyy) |
|---|---|---|---|---|
| Diabetes Mellitus | ☐ Yes | ☐ No | ☐ Missing | _____ |
| Hypertension | ☐ Yes | ☐ No | ☐ Missing | _____ |
| Cerebrovascular disease | ☐ Yes | ☐ No | ☐ Missing | _____ |
| Ischemic Heart Disease | ☐ Yes | ☐ No | ☐ Missing | _____ |
| Peripheral Vascular Disease | ☐ Yes | ☐ No | ☐ Missing | _____ |
| Malignancy | ☐ Yes | ☐ No | ☐ Missing | _____ |

If Yes, state diagnosis: _____

*Mandatory data items

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Date of test (ddmmyyyy)

HepB sAg ☐ Positive ☐ Negative ☐ Equivocal ☐ Missing _____

Anti-Hep.BsAb ☐ ≥10 IU/ml ☐ <10 IU/ml ☐ Missing _____

Anti-HCV ☐ Positive ☐ Negative ☐ Equivocal ☐ Missing _____

HCV-RNA ☐ Positive ☐ Negative ☐ Not done ☐ Missing _____

**4. CURRENT STATUS OF PATIENT**

☐ Living ☐ Deceased

Date of Death: (ddmmyyyy) | | | | | | | | |

Place of Death: _____

Cause of death: _____

**5. ELIGIBILITY FOR TRANSPLANT WAITLIST**

Limitation/Preclusion from Transplant: _____ | | |

**6. NUTRITION**

Last Serum Albumin level: _____ g/L Date: _____(dd/mm/yyyy) ☐ Missing

Laboratory method: ☐ BCG ☐ BCP ☐ Missing

**7. ANAEMIA**

Last Hb level: _____ g/dl Date: _____(dd/mm/yyyy) ☐ Missing

T SAT(Transferrrin saturation): _____ % Date: _____(dd/mm/yyyy) ☐ Missing

Serum Ferritin level: _____ ng/ml Date: _____(dd/mm/yyyy) ☐ Missing

ESA (Erythropoietin stimulating agent): ☐ Yes ☐ No ☐ Missing

(If yes, post dialysis weight required)

Post Dialysis Weight: _____ kg Date: _____(dd/mm/yyyy) ☐ Missing

Type/dosage of ESA: ☐ EPO _____u/week ☐ EBMPG (e.g. Micera) _____mcg/month

☐ Darbepoetin _____mcg/month

**8. MINERAL METABOLISM**

Serum Calcium level: _____ mmol/L Date: _____(dd/mm/yyyy) ☐ Missing

Corrected Calcium level: _____ mmol/L Date: _____(dd/mm/yyyy) ☐ Missing

Serum Phosphate level:_____ mmol/L Date: _____(dd/mm/yyyy) ☐ Missing

Serum iPTH level: _____ pmol/L Date: _____(dd/mm/yyyy) ☐ Missing

*Mandatory data items

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### 9. HAEMODIALYSIS (HD) DATA

a. **Dialysis Prescription**

Frequency of HD sessions: _____ per week  Duration of each dialysis session: _____mins

b. **Vascular Access**

Current Vascular Access: ☐ AVF ☐ AVG ☐ Non-tunneled catheter ☐ Tunneled catheter

c. **Adequacy (Monitoring of dialysis dose)**

Last URR: _____ % Date: _____(dd/mm/yyyy) ☐ Missing

Last Kt/V: _____ % Date: _____(dd/mm/yyyy) ☐ Missing

For calculation of URR

Pre-Urea: _____ mmol/l  Post-Urea: _____ mmol/l

### 10. PERITONEAL DIALYSIS (PD) DATA

**a. Adequacy of PD**

Last Weekly Total **Kt/V**: _____ % Date: _____(dd/mm/yyyy) ☐ Missing

Residual Creatinine Clearance (**rCCT**) at last
Total Creatinine Clearance (**TCCT**) measurement : _____ L/week Date:_____(dd/mm/yyyy) ☐ Missing

**b. PD Outcome**

Ever had Peritonitis: ☐ Yes ☐ No Date of 1st episode: _____(dd/mm/yyyy)

**c. Technique Survival** (To be filled only when modality change from PD to HD permanently)

Date of permanent transfer from PD to HD: | | | | | | | | | (ddmmyyyy)

Cause of permanent transfer from PD to HD: _____

### 11. TRANSPLANT DATA (To be filled only if patient has received kidney transplantation)

a. **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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**Graft not functioning,**

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

Cause of graft loss:

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

**12. DETAILS OF NOTIFYING HEALTHCARE INSTITUTION**

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

Name of Person who provide the information: _____

Date of Notification: _____ (dd/mm/yyyy)

*Mandatory data items

## EXPLANATORY NOTES

**NATIONAL REGISTRY OF DISEASES ACT (Chapter 201B)**

**(CHRONIC KIDNEY FAILURE NOTIFICATION) REGULATIONS 2011**

**Collection of additional information under section 7of the National Registry of Diseases Act:**

For update on the patient who is undergoing treatment, Singapore Renal Registry will collect additional information as listed in the Part IV of the Third schedule of the Chronic Kidney Failure Notification Regulations 2011.
The registry coordinator will contact the managers or designated staff of the healthcare institutions to arrange for the data collection.

Alternatively, the healthcare institution may complete the Year-End Follow-up Treatment form and send it to the registry.

**PROCEDURE FOR SUBMISSION**

2. Submission may be made in the following manner:

a) by hand (including courier services);
   or
b) by registered mail;
c) Please **DO NOT submit** the notification form **via email or fax**.

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