FOLLOW-UP FORM FOR LIVER DONOR

DONOR CARE REGISTRY

National Registry of Diseases Office
Health Promotion Board
Level 5, 3 Second Hospital Avenue
Singapore 168937
Tel: (65) 6435 3065 / 3063 / 3091 or E-mail: hpb_servicenrdo@hpb.gov.sg

Reg. No. | | | | | | | | | | |
Registry use

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

SECTION 1: DONOR STATUS (AT FOLLOW-UP)

Name*:

NRIC/FIN/Passport No/ Hospital No*:

Date of Consultation _____/_____/_____ (dd/mm/yyyy)

Date of Birth*:

(ddmmyyyy)

Healthcare Institution (Centre / Department / Clinic) responsible for subsequent treatment or follow-up:

_____

Height:_____m Date: _____/_____/_____ (dd/mm/yyyy) ☐ Unknown

Weight:_____kg Date: _____/_____/_____ (dd/mm/yyyy) ☐ Unknown

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

Employment status:

☐ Working Full Time, _____ ☐ Not Working ☐ Retired

☐ Working Part Time, _____ ☐ Student ☐ Housewife ☐ Unknown

SECTION 1a: EQ-5D

EQ-5D Date: _____/_____/_____ (dd/mm/yyyy) ☐ Unknown

Mobility
- ☐ I have no problems in walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed
- ☐ Unknown

Self-Care
- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself
- ☐ Unknown

Usual Activities
- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities
- ☐ Unknown

Pain/Discomfort
- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort
- ☐ Unknown

Anxiety/Depression
- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed
- ☐ Unknown

* Mandatory data items

SECTION 1b: OTHER ILLNESS SINCE LAST VISIT

Other illnesses since last visit:

☐ No

☐ Yes Date: ____/____/_____(dd/mm/yyyy) ☐ Unknown

- ☐ Urinary tract disease
- ☐ Cardiovascular disease
- ☐ Cerebrovascular disease
- ☐ Pulmonary disease
- ☐ Musculoskeletal disease
- ☐ Malignancy
- ☐ Infection
- ☐ Accident
- ☐ Others, specify _____

☐ Unknown

SECTION 1c: ADMISSION SINCE LAST VISIT

Admissions to hospital since last visit:

☐ No

☐ Yes Date: ____/____/_____(dd/mm/yyyy) ☐ Unknown

☐ Day Surgery Admission

- ☐ Urinary tract disease
- ☐ Cardiovascular disease
- ☐ Cerebrovascular disease
- ☐ Pulmonary disease
- ☐ Musculoskeletal disease
- ☐ Malignancy
- ☐ Infection
- ☐ Accident
- ☐ Others, specify _____

☐ Unknown

SECTION 2: INVESTIGATIONS (AT FOLLOW-UP)

Liver Panel:

☐ Unknown

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

ALT _____U/L ☐ Unknown

ALP _____ U/L ☐ Unknown

AST _____U/L ☐ Unknown

Total Bilirubin _____ ummol/L ☐ Unknown

Conjugated Bilirubin _____ ummol/L ☐ Unknown

Unconjugated Bilirubin_____ ummol/L ☐ Unknown

Albumin _____g/L ☐ Unknown

Total Protein _____g/L ☐ Unknown

SECTION 2: INVESTIGATIONS (AT FOLLOW-UP)

Full Blood Count:

☐ Unknown

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

WBC _____ x 10^9 / L or ths/uL#	☐ Unknown	Haemoglobin _____g/dL	☐ Unknown
RBC _____ x 10^{12} / L or mil/uL#	☐ Unknown	Haematocrit _____%	☐ Unknown
Platelets _____ x 10^9 / L or ths/uL#	☐ Unknown	MCV _____fL	☐ Unknown
Neutrophils _____ x 10^9 / L or %#	☐ Unknown	MCH _____pg	☐ Unknown
Lymphocytes _____ x 10^9 / L or %#	☐ Unknown	MCHC _____g/dL	☐ Unknown
Monocytes _____ x 10^9 / L or %#	☐ Unknown	MPV _____fL	☐ Unknown
Eosinophils _____ x 10^9 / L or %#	☐ Unknown	RDW _____%	☐ Unknown
Basophils _____ x 10^9 / L or %#	☐ Unknown		
LUC _____ x 10^9 / L or %#	☐ Unknown		

Prothrombin Time

☐ Unknown

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

Prothrombin Time _____seconds

Ultrasound:

☐ Unknown

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

☐ No abnormalities

☐ Fatty Liver

☐ Others, Specify_____

CT Scan/MRI :

☐ Unknown

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

☐ No abnormalities

☐ Fatty Liver

☐ Others, Specify_____

ERCP/ MRCP:

☐ Unknown

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

☐ ERCP _____

☐ MRCP _____

☐ Others, Specify_____

Please circle one unit of measurement

SECTION 3: ADVERSE CONDITION RELATING TO LIVER	
Liver Failure: ☐ Yes ☐ No	Date of Liver Failure: _____/_____/_____(dd/mm/yyyy) Cause of Liver failure: _____ _____
On Transplant waiting list: ☐ Yes ☐ No	Reason Not on list: _____ _____
SECTION 4: VITAL STATUS	
☐ Alive ☐ Dead	Date of Death: _____/_____/_____ (dd/mm/yyyy) Cause of Death: _____ Place of Death: _____
SECTION 5: DETAILS OF NOTIFYING HEALTHCARE INSITUTION	
Name of Notifying Healthcare Institution*: _____ Name of Notifying Person: _____ Date of Notification: _____/_____/_____ (dd/mm/yyyy)	

* Mandatory data items

EXPLANATORY NOTES

CASES TO BE NOTIFIED

1. Please notify cases immediately and not later than 3 months after patient had undergone Liver Post Hepatic Resection (Donor) Treatment Follow-up.

PROCEDURE FOR SUBMISSION

2. Submission may be made in the following manner:

a) by hand (including courier services); or
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)

(LIVER-POST HEPATIC RESECTION (DONOR) NOTIFICATION) REGULATIONS 2009

Notification of a person undergoing any treatment for liver-post hepatic resection (donor) is mandatory in accordance to Section 6(1) of the National Registry of Diseases Act.

Please duly fill in the minimum (mandatory) data items (with asterisks) – 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. Name of notifying healthcare institution (including department).

In pursuant to Section 7(2) of the NRD Act, you may 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.