CONFIDENTIAL **

DONOR CARE REGISTRY

NEW CASE REGISTRATION FORM FOR KIDNEY DONOR

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: PARTICULARS OF DONOR

Name*:

NRIC/FIN/Passport No/Hospital No*:

Resident Status: ☐ Singapore Citizen ☐ Singapore PR ☐ Others, specify: _____

Gender: ☐ Male ☐ Female

Date of Birth*: (ddmmyyyy)

Country of Birth: ☐ Singapore ☐ China ☐ Malaysia ☐ Others, specify: _____ ☐ Indonesia ☐ India ☐ Unknown

Ethnic Group: ☐ Chinese ☐ Malay ☐ Indian ☐ Eurasian ☐ Others, specify: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Unknown

Highest Educational Level:
- ☐ Not available
- ☐ No Formal Education
- ☐ Low Primary
- ☐ PSLE (Certificate)
- ☐ Secondary (No O Level Cert)
- ☐ GCE N Level passes
- ☐ GCE O Level passes
- ☐ GCE A Level passes
- ☐ Diploma
- ☐ University and above

Employment status:
- ☐ Working Full Time: _____
- ☐ Working Part Time: _____
- ☐ Not Working ☐ Retired
- ☐ Student ☐ Housewife ☐ Unknown

Relationship to Recipient: ☐ Unknown

Biologically related: ☐ Parent ☐ Offspring ☐ Identical twin ☐ Sibling ☐ Others, specify: _____

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

Others : ☐ Directed ☐ Non- Directed ☐ Others, specify: _____

SECTION 2: PARTICULARS OF RECIPIENT

Name:

NRIC/FIN/Passport No/Hospital No:

Resident Status: ☐ Singapore Citizen ☐ Singapore PR ☐ Others, specify: _____

Gender: ☐ Male ☐ Female

Date of Birth: (ddmmyyyy)

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

SECTION 2: PARTICULARS OF RECIPIENT

Ethnic Group: ☐ Chinese ☐ Malay ☐ Indian ☐ Eurasian

☐ Others, specify: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated

☐ Divorced ☐ Unknown

Recipient Healthcare Institution: ☐ SGH ☐ NUH ☐ MEH ☐ Raffles ☐ Gleneagles

☐ Others, specify:_____

SECTION 3: DONOR BASELINE INFORMATION (PRE-DONATION)

Date of Baseline Information: _____/_____/_____(dd/mm/yyyy)

Blood Pressure _____/_____ mmHg ☐ Unknown

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

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

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

SECTION 3a: 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

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SECTION 3b: RISK FACTOR

Diabetes: ☐ Yes ☐ No ☐ Unknown	Oral Glucose Tolerance test: ☐ Unknown Date: _____/_____/_____ (dd/mm/yyyy) ☐ Fasting _____mmol/L ☐ Unknown ☐ 60mins _____mmol/L ☐ Unknown ☐ 120mins _____mmol/L ☐ Unknown
Hyperlipidemia: ☐ Yes ☐ No ☐ Unknown	LDL Cholesterol : ☐ Normal ☐ Elevated Date: _____/_____/_____(dd/mm/yyyy) ☐ Unknown Triglyceride: ☐ Normal ☐ Elevated Date: _____/_____/_____(dd/mm/yyyy) ☐ Unknown

SECTION 3c: INVESTIGATIONS

Urine FEME(RBC): ☐ Unknown	Urine FEME(RBC): _____/hpf or _____/uL	Date: _____/_____/_____(dd/mm/yyyy)
Urine FEME(WBC): ☐ Unknown	Urine FEME(WBC): _____/hpf or _____/uL	
Serum Creatinine: ☐ Unknown	Serum Creatinine: _____ mg/dL or umol/L# Date: _____/_____/_____(dd/mm/yyyy) Creatinine measured with IDMS standard : ☐ Yes ☐ No ☐ Unknown	
Creatinine Clearance or Radionuclide GFR: ☐ Unknown	Creatinine Clearance:_____mL/min Date: _____/_____/_____(dd/mm/yyyy) Radionuclide GFR:_____ mL/min/1.73m^2 Date: _____/_____/_____(dd/mm/yyyy)	
24HR Urine protein : ☐ Unknown	24HR Urine protein :_____ g/day or mg/day# Date: _____/_____/_____(dd/mm/yyyy)	

X-ray/Scan: ☐ Yes ☐ No ☐ Unknown Date: _____/_____/_____(dd/mm/yyyy)

Other abnormalities:
(E.g. Stones/Cysts on X-rays)

☐ Stone (Right / Left / Both Kidneys) #
☐ Cyst (Right / Left / Both Kidneys) #
☐ Others, specify_____

Delete where applicable

SECTION 3d: MEDICATIONS

	Yes	Number of Drugs	No	Unknown
Anti-Hypertensives:	☐	☐	☐	☐
Hypolipidemics:	☐	☐	☐	☐

SECTION 4: DATA RELATED TO DONOR NEPHRECTOMY

Date of Nephrectomy*: _____/_____/_____(dd/mm/yyyy)

Place of Surgery: ☐SGH ☐ NUH ☐ MEH ☐Raffles ☐ Gleneagles
☐ Others, specify:_____

Name of Lead Surgeon: _____

Type of Nephrectomy: ☐ Hand-Assisted Laparoscopic Donor Nephrectomy ☐ Laparoscopic
☐ Conversion from Laparoscopic to open ☐ Open

SECTION 4a: COMPLICATIONS DURING HOSPITALISATION

Renal Failure/Impairment: ☐ Yes Date: _____/_____/_____(dd/mm/yyyy)
☐ No
☐ Unknown

Serum Creatinine:	Serum Creatinine: _____ mg/dL or umol/L# Date: _____/_____/_____ (dd/mm/yyyy)
☐ Unknown	Creatinine measured with IDMS Standard : ☐ Yes ☐ No ☐ Unknown
	# Delete where applicable

Surgical 1: _____

Surgical 2: _____

Medical 1: _____

Medical 2: _____

Other 1: _____

Other 2: _____

Date of Initial Discharge: _____/_____/_____(dd/mm/yyyy)	Live Donor Discharge Disposition ☐ Alive ☐ Dead

SECTION 5: DETAILS OF NOTIFYING HEALTHCARE INSTITUTION

Name of Notifying Healthcare Institution*: _____

Name of Notifying Person: _____

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

* Mandatory data

EXPLANATORY NOTES

CASES TO BE NOTIFIED

1. Please notify cases immediately and not later than 3 months after patient had undergone Single Live Kidney Nephrectomy (Donor).

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)

(SINGLE KIDNEY-POST NEPHRECTOMY (DONOR) NOTIFICATION) REGULATIONS 2009

Notification of single kidney-post nephrectomy (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 (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. Name of notifying healthcare institution (including department).
5. Date of nephrectomy (for new cases).

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.

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