NEW CASE REGISTRATION 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: 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/Passport No/Hospital No: ☐☐☐☐☐☐☐☐☐☐

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

Gender: ☐ Male ☐ Female

Date of Birth: ☐☐☐☐☐☐☐☐ (ddmmyyyy)

* Mandatory data items

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)

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

Weight:_____kg 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	Self-Care
☐ I have no problems in walking about	☐ I have no problems with self-care
☐ I have some problems in walking about	☐ I have some problems washing or dressing myself
☐ I am confined to bed	☐ I am unable to wash or dress myself
☐ Unknown	☐ Unknown
Usual Activities	**Pain/Discomfort**
☐ I have no problems with performing my usual activities	☐ I have no pain or discomfort
☐ I have some problems with performing my usual activities	☐ I have moderate pain or discomfort
☐ I am unable to perform my usual activities	☐ I have extreme pain or discomfort
☐ Unknown	☐ Unknown

Anxiety/Depression

☐ I am not anxious or depressed

☐ I am moderately anxious or depressed

☐ I am extremely anxious or depressed

☐ Unknown

SECTION 3b: INVESTIGATIONS

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

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/CT Scan/MRI:

☐ Unknown

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

☐ No abnormalities

☐ Fatty Liver

☐ Others, Specify_____

Please circle one unit of measurement

SECTION 4: DATA RELATED TO DONOR HEPATIC RESECTION

Date of Hepatic Resection*: _____/_____/_____ (dd/mm/yyyy)

Place of Surgery: ☐ SGH ☐ NUH ☐ MEH ☐ Raffles ☐ Gleneagles

☐ Others, specify:_____

Type of Hepatic Resection: _____

SECTION 4a: COMPLICATIONS DURING HOSPITALISATION

☐ No Complication

Liver Failure/Impairment : ☐ Yes Date: _____/_____/_____(dd/mm/yyyy)

☐ No

☐ Unknown

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 items

EXPLANATORY NOTES

CASES TO BE NOTIFIED

1. Please notify cases immediately and not later than 3 months after patient had undergone Liver Hepatic Resection (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)

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

Notification of liver-post hepatic resection (donor) is mandatory in accordance to 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).
5. Date of hepatic resection (for new cases).

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.