# YEARLY FOLLOW-UP FORM FOR KIDNEY 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 (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:

_____

Blood Pressure : _____/_____ mmHg ☐ 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: COMPLICATIONS WITHIN 6 WEEKS OF DISCHARGE (following Nephrectomy)**

| **Complications – please tick accordingly** | **State Date if available: (dd/mm/yyyy)** |
|---|---|
| ☐ No complication | |
| ☐ Renal Failure/Impairment | Date: _____/_____/_____ |
| Serum Creatinine: _____umol/L or mg/dL # ☐ Unknown<br>Creatinine measured with IDMS Standard : ☐ Yes ☐ No ☐ Unknown | Date: _____/_____/_____ |
| ☐ Pulmonary embolism | Date: _____/_____/_____ |

* Mandatory data items # Delete where applicable



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**SECTION 1a: COMPLICATIONS WITHIN 6 WEEKS OF DISCHARGE (following Nephrectomy)**

| | |
|---|---|
| ☐ Wound Infection | Date: _____/_____/_____ |
| ☐ Incisional Pain | Date: _____/_____/_____ |

Other Re-Hospitalisation

State reason: _____

Duration of Re-Hospitalisation: _____days

Other complication 1:_____

Other complication 2: _____

**SECTION1b: EQ-5D:**

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

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

Anxiety/Depression

☐ I am not anxious or depressed

☐ I am moderately anxious or depressed

☐ I am extremely anxious or depressed

☐ Unknown

| SECTION 2: RISK FACTORS (AT FOLLOW-UP) | |
|---|---|
| Diabetes:<br>☐ Yes<br>☐ No<br>☐ Unknown | If Diabetic, Treatment for diabetes:<br>☐ Diet ☐ Oral Hypoglycemics ☐ Insulin ☐ Unknown<br>HbA1C: _____% Date: ___/___/____ (dd/mm/yyyy) ☐ Unknown<br><br>If Not Diabetic,<br>☐ Impaired Fasting Glycemia ☐ Impaired Glucose<br>☐ Unknown |
| Hyperlipidemia:<br>☐ Yes<br>☐ No<br>☐ Unknown | LDL Cholesterol: ☐ Normal ☐ Elevated Date: _____/_____/_____(dd/mm/yyyy) ☐ Unknown<br>Triglyceride: ☐ Normal ☐ Elevated Date: _____/_____/_____(dd/mm/yyyy) ☐ Unknown |
| **SECTION 3: INVESTIGATIONS (AT FOLLOW-UP)** | |
| Fasting Blood Sugar:<br>☐ Unknown | Fasting Blood Sugar: _____mmol/L Date: _____/_____/_____(dd/mm/yyyy) |
| Serum Creatinine:<br>☐ Unknown | Serum Creatinine: _____umol/L or mg/dL# Date: ____/____/_____ (dd/mm/yyyy)<br>Creatinine measured with IDMS standard: ☐ Yes ☐ No ☐ Unknown |
| Creatinine Clearance<br>or Radionuclide GFR:<br>☐ Unknown | Creatinine Clearance: _____ mL/min Date: _____/_____/_____ (dd/mm/yyyy)<br>Or Radionuclide GFR : _____ mL/min1.73m² Date: _____/_____/_____ (dd/mm/yyyy) |
| Urine FEME(RBC):<br>☐ Unknown | Urine FEME(RBC): _____ /hpf or _____/uL<br>Date: _____/_____/_____ (dd/mm/yyyy) |
| Urine FEME(WBC):<br>☐ Unknown | Urine FEME(WBC): _____ /hpf or _____/uL |
| 24Hr Urine Protein<br>or Urine protein<br>/creatinine ratio:<br>☐ Unknown | 24hr urine protein: _____g/day or mg/day # Date: ____/____/_____(dd/mm/yyyy)<br>Urine protein/creatinine ratio:_____ g/g, mg/mg, mg/g or mg/mmol# Date: ____/____/_____ (dd/mm/yyyy) |

# Delete where applicable

## SECTION 4: MEDICATIONS (AT FOLLOW-UP)

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

## SECTION 5: COMPLICATIONS (AT FOLLOW-UP)

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

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 5: COMPLICATIONS (AT FOLLOW-UP)**

| | |
|---|---|
| CKD5:<br>☐ Yes<br>☐ No | Date of CKD5: ____/____/_____ (dd/mm/yyyy)<br>Cause: _____ |
| On Transplant waiting list:<br>☐ Yes<br>☐ No | If not on Transplant waiting list:<br>Reason not on list: _____ |

**SECTION 6: VITAL STATUS**

| | |
|---|---|
| ☐ Alive<br>☐ Dead | Date of Death: _____/_____/_____ (dd/mm/yyyy)<br>Cause of Death: _____<br>Place of Death: _____ |

**SECTION 7: 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 commenced Single Live Kidney Post Nephrectomy (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)

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

Notification of a person undergoing any treatment for 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).

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.