CONFIDENTIAL**

SINGAPORE RENAL REGISTRY

National Registry of Diseases Office
Health Promotion Board
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Singapore 168937
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DIAGNOSIS OR COMMENCEMENT OF TREATMENT OF CHRONIC KIDNEY FAILURE NOTIFICATION FORM

SRR No. ☐☐☐☐☐☐☐☐☐☐
Registry use

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

1. REFERRING OR TREATING HEALTHCARE INSTITUTION

Referral Clinic / Centre: _____ ☐☐☐

Current Centre: _____ ☐☐☐

Date treatment started at current centre: _____ (ddmmyyyy)

Current modality of treatment: ☐ HD ☐ HDF ☐ APD ☐ CAPD ☐ TRANSPLANT ☐ CONSERVATIVE TREATMENT

☐ OTHERS, Please specify: _____

2. PARTICULARS OF PATIENT

Name*:

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

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

Date of Birth*: (ddmmyyyy) ☐☐☐☐☐☐☐☐

Gender*: ☐ Male ☐ Female

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

3. DIAGNOSTIC INFORMATION

Primary Renal Disease leading to Chronic Kidney Failure: _____

Date reached Chronic Kidney Failure: ☐☐☐☐☐☐☐☐

Serum Creatinine level at diagnosis: _____umol/L / mg/dl Date: _____ (dd/mm/yyyy)

eGFR at diagnosis: _____ml/min/1.73m^2

eGFR at first dialysis: _____ml/min/1.73m^2

Serum Creatinine level at first dialysis: _____umol/L / mg/dl Date:_____(dd/mm/yyyy)

*Mandatory data items
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SRR NO. ☐☐☐☐☐☐☐☐☐☐

4. CO-MORBID CONDITIONS

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

Date of Diagnosis (ddmmyyy)

Diabetes Mellitus	☐Yes	☐No	☐Missing	
If Yes	☐Type I	☐Type II	☐Unspecified	_____
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: _____

_____

Date of test (ddmmyyyy)

HepBs Ag	☐Positive	☐Negative	☐Equivocal	☐Missing	_____
Anti-HepBs Ab	☐≥10 IU/ml	☐<10 IU/ml		☐Missing	_____
Anti-HCV	☐Positive	☐Negative	☐Equivocal	☐Missing	_____
HCV-RNA	☐Positive	☐Negative	☐Not done	☐Missing	_____

5. CURRENT STATUS OF PATIENT

☐ Living ☐ Deceased

Date of Death: (ddmmyyyy) ☐☐☐☐☐☐☐☐

Place of Death: _____

Cause of death: _____

6. ELIGIBILITY FOR TRANSPLANT WAITLIST

Limitation/Preclusion from Transplant: _____ ☐☐☐

7. DETAILS OF NOTIFYING HEALTHCARE INSTITUTION

Name of Notifying Healthcare Institution (including department): _____

Name of Person who made the notification: _____

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

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EXPLANATORY NOTES

CASES TO BE NOTIFIED

1. Please notify cases within than 3 months after patient has been diagnosed or treated for Chronic Kidney Failure

PROCEDURE FOR SUBMISSION

2. Submission may be made in the following manner:
   a) E-services – available at www.hpp.moh.gov.sg;
      or
   b) Hardcopy form - by hand (including courier services) or registered mail;
      or
   c) by using such secured electronic notification system as may be approved by the Registrar.

   N.B. Please DO NOT submit the notification form via email or fax.

NATIONAL REGISTRY OF DISEASES ACT (Chapter 201B)

(CHRONIC KIDNEY FAILURE NOTIFICATION) REGULATIONS 2011

Notification of Chronic Kidney Failure 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. Gender

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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