

**CONFIDENTIAL \*\***

**KIDNEY TRANSPLANT FORM**

**SINGAPORE RENAL REGISTRY**

National Registry of Diseases Office  
Health Promotion Board  
Level 5, 3 Second Hospital Avenue  
Singapore 168937  
Tel: (65) 6435 3076 / 3039 or E-mail: hpb\_servicenrdo@hpb.gov.sg

SRR No. 

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Registry use

E-Notification: [www.hpp.moh.gov.sg](http://www.hpp.moh.gov.sg)

**1. REFERRING / TREATING HEALTHCARE INSTITUTION**

Referral Clinic / Centre: \_\_\_\_\_ 

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Current Centre: \_\_\_\_\_ 

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Date of first follow-up treatment (post transplant): \_\_\_\_\_ (ddmmyyyy)

**2. PARTICULARS OF PATIENT**

Name*: _____  _____	NRIC/ Passport No/FIN/Hospital Registration No*: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>												
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth*: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> (ddmmyyyy)												

**3. DIALYSIS HISTORY**

Was patient on dialysis prior to transplant:     Yes       No  
  
If No, please proceed to Item 4  
If Yes, please proceed to item 5

**4. GLOMERULAR FILTRATION RATE (GFR) AT TIME OF TRANSPLANT**

Serum Creatinine level at time of transplant: \_\_\_\_\_ umol/L / mg/dl      Date: \_\_\_\_\_ (dd/mm/yyyy)       Missing  
(The measurement of Serum Creatinine level closest to (before) the date of transplant)

eGFR: at time of transplant \_\_\_\_\_ ml/min/1.73m<sup>2</sup>      Date: \_\_\_\_\_ (dd/mm/yyyy)       Missing

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

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**5. TRANSPLANT INFORMATION**

Date of Transplant: 

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 (ddmmyyyy)

Place where patient underwent Transplant: \_\_\_\_\_

If transplant was done Overseas, pls specify Country: \_\_\_\_\_

and Centre: \_\_\_\_\_

Graft Number : \_\_\_\_\_

**6. DONOR INFORMATION**

Date of Birth: 

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 (ddmmyyyy)      Age: 

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Gender:             Male                       Female                       Missing

Ethnic Group:     Chinese                       Malay                       Indian                       Eurasian

Others, specify: \_\_\_\_\_

**Type I. Living Donor**

Biologically related:     Parents                       Off Spring                       Identical twin                       Sibling

Others, specify: \_\_\_\_\_

Emotionally related:     Spouse                       Friend                       Others, specify: \_\_\_\_\_

Neither biologically nor emotionally related:     Good Samaritan                       Others, specify: \_\_\_\_\_

**Type II. Deceased Donor**     Heart Beating                       Non-heart beating                       Missing

**7. GRAFT STATUS**

Graft Functioning     Yes                       No

If yes,  
Current Serum Creatinine level : \_\_\_\_\_ umol/L / mg/dl      Date: \_\_\_\_\_ (dd/mm/yyyy)       Missing

eGFR: \_\_\_\_\_ ml/min/1.73m<sup>2</sup>      Date: \_\_\_\_\_ (dd/mm/yyyy)       Missing

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**If Graft is not functioning**

Date of graft loss:: \_\_\_\_\_(dd/mm/yyyy)       Missing

Cause of graft loss:

- Acute Rejection
- Hyperacute Rejection
- Chronic Rejection
- Primary non-function
- Recurrent disease
- Chronic allograft Nephropathy
- Graft thrombosis
- Ureteric obstruction
- Infection
- Other Surgical complication
- Non-compliance
- Unknown
- Others, specify:\_\_\_\_\_

**8. 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 3 months after the completion of the Kidney Transplantation for Chronic Kidney Failure.

### PROCEDURE FOR SUBMISSION

2. Submission may be made in the following manner:
  - a) by hand (including courier services)
  - 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) (CHRONIC KIDNEY FAILURE NOTIFICATION) REGULATIONS 2011

Notification of patient who has received kidney transplant for 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.

N.B. If this patient has been newly diagnosed with Kidney Failure, please complete the **Diagnosis or Commencement of Treatment of Chronic Kidney Failure notification form** together with the Kidney Transplant form to complete this notification.