

CONFIDENTIAL**

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

YEAR-END FOLLOW-UP TREATMENT FORM

SRR No.

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Registry use

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

1. TREATING HEALTHCARE INSTITUTION

Current Centre: _____

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Date treatment started at current centre: _____ (ddmmyyy)

2. PARTICULARS OF PATIENT

Name*: _____

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

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Gender*: Male Female

Date of Birth*: _____ (ddmmyyy)

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3. CO-MORBID CONDITIONS

Smoking status: Never Ex-smoker Current smoker Missing

Diabetes Mellitus Yes No Missing Date of Diagnosis (ddmmyyy)

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: _____

*Mandatory data items

** THE INFORMATION IN THE FORM NEEDS TO BE KEPT CONFIDENTIAL AFTER THE FORM HAS BEEN FILLED

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	Date of test (ddmmyyyy)
HepB sAg <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Missing	_____
Anti-Hep.BsAb <input type="checkbox"/> ≥10 IU/ml <input type="checkbox"/> <10 IU/ml <input type="checkbox"/> Missing	_____
Anti-HCV <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Missing	_____
HCV-RNA <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Missing	_____

4. CURRENT STATUS OF PATIENT

<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Date of Death: (ddmmyyyy) <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></tr></table>								
Place of Death: _____	Cause of death: _____								

5. ELIGIBILITY FOR TRANSPLANT WAITLIST

Limitation/Preclusion from Transplant: _____

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6. NUTRITION

Last Serum Albumin level: _____ g/L Date: _____ (dd/mm/yyyy) Missing

Laboratory method: BCG BCP Missing

7. ANAEMIA

Last Hb level: _____ g/dl Date: _____ (dd/mm/yyyy) Missing

T SAT(Transferrin saturation): _____ % Date: _____ (dd/mm/yyyy) Missing

Serum Ferritin level: _____ ng/ml Date: _____ (dd/mm/yyyy) Missing

ESA (Erythropoietin stimulating agent): Yes No Missing

(If yes, post dialysis weight required)

Post Dialysis Weight: _____ kg Date: _____ (dd/mm/yyyy) Missing

Type/dosage of ESA: EPO _____ u/week EBMPG (e.g. Micera) _____ mcg/month

Darbepoetin _____ mcg/month

8. MINERAL METABOLISM

Serum Calcium level: _____ mmol/L Date: _____ (dd/mm/yyyy) Missing

Corrected Calcium level: _____ mmol/L Date: _____ (dd/mm/yyyy) Missing

Serum Phosphate level: _____ mmol/L Date: _____ (dd/mm/yyyy) Missing

Serum iPTH level: _____ pmol/L Date: _____ (dd/mm/yyyy) Missing

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9. HAEMODIALYSIS (HD) DATA

a. Dialysis Prescription

Frequency of HD sessions: _____ per week Duration of each dialysis session: _____ mins

b. Vascular Access

Current Vascular Access: AVF AVG Non-tunneled catheter Tunneled catheter

c. Adequacy (Monitoring of dialysis dose)

Last URR: _____ % Date: _____(dd/mm/yyyy) Missing

Last Kt/V: _____ % Date: _____(dd/mm/yyyy) Missing

For calculation of URR

Pre-Urea: _____ mmol/l Post-Urea: _____ mmol/l

10. PERITONEAL DIALYSIS (PD) DATA

a. Adequacy of PD

Last Weekly Total Kt/V: _____ % Date: _____(dd/mm/yyyy) Missing

Residual Creatinine Clearance (rCCT) at last
Total Creatinine Clearance (TCCT) measurement : _____ L/week Date: _____(dd/mm/yyyy) Missing

b. PD Outcome

Ever had Peritonitis: Yes No Date of 1st episode: _____(dd/mm/yyyy)

c. Technique Survival (To be filled only when modality change from PD to HD permanently)

Date of permanent transfer from PD to HD:

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 (ddmmyyyy)

Cause of permanent transfer from PD to HD: _____

11. TRANSPLANT DATA (To be filled only if patient has received kidney transplantation)

a. Graft status

Graft Functioning: Yes No

If yes,

Current Serum Creatinine level : _____ umol/L / mg/dl Date: _____(dd/mm/yyyy) Missing

eGFR: _____ ml/min/1.73m² Date: _____(dd/mm/yyyy) Missing

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Graft not functioning,

Date of graft loss: _____(dd/mm/yyyy)

Missing

Cause of graft loss:

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

12. DETAILS OF NOTIFYING HEALTHCARE INSTITUTION

Name of Notifying Healthcare Institution (including department)*: _____

Name of Person who provide the information: _____

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

*Mandatory data items

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EXPLANATORY NOTES

NATIONAL REGISTRY OF DISEASES ACT (Chapter 201B) (CHRONIC KIDNEY FAILURE NOTIFICATION) REGULATIONS 2011

Collection of additional information under section 7 of the National Registry of Diseases Act:

For update on the patient who is undergoing treatment, Singapore Renal Registry will collect additional information as listed in the Part IV of the Third schedule of the Chronic Kidney Failure Notification Regulations 2011. The registry coordinator will contact the managers or designated staff of the healthcare institutions to arrange for the data collection.

Alternatively, the healthcare institution may complete the Year-End Follow-up Treatment form and send it to the registry.

PROCEDURE FOR SUBMISSION

2. Submission may be made in the following manner:
 - a) by hand (including courier services);
or
 - b) by registered mail;
 - c) Please **DO NOT submit** the notification form **via email or fax**.

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

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