CONFIDENTIAL**

DONOR CARE REGISTRY

National Registry of Diseases Office
Health Promotion Board
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Singapore 168937
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YEARLY FOLLOW-UP FORM FOR KIDNEY DONOR

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 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	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 2: RISK FACTORS (AT FOLLOW-UP)	
Diabetes: ☐ Yes ☐ No ☐ Unknown	If Diabetic, Treatment for diabetes: ☐ Diet ☐ Oral Hypoglycemics ☐ Insulin ☐ Unknown HbA1C: _____% Date: ___/___/____ (dd/mm/yyyy) ☐ Unknown
	If Not Diabetic, ☐ Impaired Fasting Glycemia ☐ Impaired Glucose ☐ Unknown
Hyperlipidemia: ☐ Yes ☐ No ☐ Unknown	LDL Cholesterol: ☐ Normal ☐ Elevated Date: _____/_____/_____(dd/mm/yyyy) ☐ Unknown Triglyceride: ☐ Normal ☐ Elevated Date: _____/_____/_____(dd/mm/yyyy) ☐ Unknown
SECTION 3: INVESTIGATIONS (AT FOLLOW-UP)	
Fasting Blood Sugar: ☐ Unknown	Fasting Blood Sugar: _____mmol/L Date: _____/_____/_____(dd/mm/yyyy)
Serum Creatinine: ☐ Unknown	Serum Creatinine: _____umol/L or mg/dL# Date: ____/____/_____ (dd/mm/yyyy) Creatinine measured with IDMS standard: ☐ Yes ☐ No ☐ Unknown
Creatinine Clearance or Radionuclide GFR: ☐ Unknown	Creatinine Clearance: _____ mL/min Date: _____/_____/_____ (dd/mm/yyyy) Or Radionuclide GFR : _____ mL/min1.73m² Date: _____/_____/_____ (dd/mm/yyyy)
Urine FEME(RBC): ☐ Unknown	Urine FEME(RBC): _____ /hpf or _____/uL Date: _____/_____/_____ (dd/mm/yyyy)
Urine FEME(WBC): ☐ Unknown	Urine FEME(WBC): _____ /hpf or _____/uL
24Hr Urine Protein or Urine protein /creatinine ratio: ☐ Unknown	24hr urine protein: _____g/day or mg/day # Date: ____/____/_____(dd/mm/yyyy) 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: ☐ Yes ☐ No	Date of CKD5: ____/____/_____ (dd/mm/yyyy) Cause: _____
On Transplant waiting list: ☐ Yes ☐ No	If not on Transplant waiting list: Reason not on list: _____

SECTION 6: VITAL STATUS

☐ Alive ☐ Dead	Date of Death: _____/_____/_____ (dd/mm/yyyy) Cause of Death: _____ 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

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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.