HAEMODIALYSIS ANNUAL RETURN

Please complete this form for each patient on dialysis at your centre for year [ ][ ][ ][ ]

Instruction to select boxes: 1) ☑ check one or more boxes 2) ⦿ check one box only

** - Compulsory
# - For RESOLVE Study

Name	______
NRR Registration Number	**Patient ID** ______ **RRT ID** ______ **Notif ID** ______ *Nota: Jika pesakit tiada nombor pendaftaran NRR, tolong isikan borang Dialysis Patient Notification' dan pulang bersama borang ini*
Centre name	______ **SDP ID** ______

PART 1 - A : DETAILS & CATEGORY

1. ** **HD Category**	○ Centre ○ Home ○ Office
2. **Patient Yearly Height** #	______ cm
3. ** **Assistance to perform HD**	○ Self-care (Minimal assistance required) ○ Partial self-care (Some assistance required) ○ Completely assisted

PART 1 - B : VASCULAR ACCESS

Vascular Access Insertion/Creation

1. ** **Date of Vascular Access Insertion/Creation**	______	2. **Date Remove** ______
3. **Access created by**	______	
4. **Dr. perform category**	○ Urologist ○ Plastic ○ Physician ○ Vascular surgeon ○ Hand-microsurgery ○ Nephrologist ○ Gen surgeon ○ Cardiothoracic ○ Others, specify ______	
5. **Facility sector where access is created**	○ MOH ○ MOE ○ MOD ○ Private ○ Others, specify ______	
6. ** **Current type of access in this patient** #	**Access for HD**	○ Wrist RCF ○ BCF ○ BBF ○ Graft && ○ HD Catheter !!
	Access for HD side	○ Left ○ Right
	Graft type &&	○ Native Vein ○ Synthetic
	HD Catheter type !!	○ Cuffed Catheter ○ Non-cuffed Catheter
	HD Catheter site !!	○ Internal Jugular Vein (IJV) ○ Subclavian ○ Femoral ○ Others, specify ______

Vascular Access Outcome during Insertion

7. **Date of Assessment** *(If unsure, put estimated date)*	______
8. ** **Current Access in this patient had become difficulties as follows:**	☐ No difficulties ☐ Difficulty in placement of needle for HD ☐ Difficulty in obtaining desired blood flow rate ☐ Other difficulties, specify ______
9. ** **Has the following vascular access complications occurred in this patient?**	☐ No Complication ☐ Access related infection = local / systemic ☐ Access failure due to thrombosis ☐ Distal limb ischaemia / vascular steal ☐ Haemorrhage/ peri access haematoma ☐ Venous outflow obstruction / high venous pressure ☐ Aneurysmal dilatation ☐ Carpal tunnel syndrome ☐ Oedema / access limb swelling ☐ Fistula / AV Graft infection ☐ Catheter Related Blood Stream Infection (CRBSI) ☐ Other complications
10. ** **Blood flow rate obtained**	______ ml/min

PART 1 - C : HD PRESCRIPTION

01. **Date prescription	______________	02. Date Stop Prescription	______________
03. Prescribed by	______________		
04. **Type of dialysis	○ HD	○ HDF	
05. Dialyser Brand & Model #	______________		
06. Membrane Type	______________		
07. Dialyser KUF	______________	08. **Dialyser Flux	○ Low (KUF < 20) ○ High (KUF >= 20)
09.** Number of use	○ Single use	○ More than one, specify	○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ >12
10. **Blood flow rate #	______________(ml/min)	11.** Dialysate Flow	______________(ml/min)
12. **Number of sessions per week #	______________	13. **Hours per session #	______________
14. **HD Dialysate	Dialysate used	○ Bicarbonate Solution (Solution A (Acid) & B (Bicarbonate))	○ Bicarbonate Powder (Solution A (Acid) + Bicarbonate Powder)
	Dialysate Delivery method	○ Pre-prepared (Canister, Powder)	○ Central delivery system
	Dialysate Calcium concentrate #	○ 1 ○ 1.25 ○ 1.5 ○ 1.75 ○ Others, specify ______________	
	Dialysate Sodium #	______________ mmol/L	

PART 1 - D : FUNDING FOR HD

**Primary Funding Source

- ○ Government funded → ○ Government centres ○ JPA reimbursed ○ Government subsidy
- ○ SOCSO
- ○ Zakat / Baitumal
- ○ NGO/Charity body funded → ○ Religious Group ○ Voluntary Group
- ○ Self funded
- ○ Employer subsidised
- ○ Insurance
- ○ Others, specify ______________

Other Funding Source(s)

- ☐ Government funded → ○ Government centres ○ JPA reimbursed ○ Government subsidy
- ☐ SOCSO
- ☐ Zakat / Baitumal
- ☐ NGO/Charity body funded → ○ Religious Group ○ Voluntary Group
- ☐ Self funded
- ☐ Employer subsidised
- ☐ Insurance
- ☐ Others, specify ______________

For source of funding government other specify, only specify government sources and not all the others, i.e. not SOCSO, Zakat, Self funding, NGO, etc

PART 1 - E : ESA/EPO/ERYTHROPOEITIN MEDICATION & FUNDING

Is there any ESA medication this year? ○ Yes ○ No

**ESA/EPO/Erythropoetin Medication

○ Binocrit ○ Darbepoetin ○ Eprex ○ Erysaa (Epoetin Alfa)

○ Mircera ○ NESP (Darbepoetin alfa) ○ Recormon ○ Other Erythropoiesis-Stimulating Agents (ESAs)

Specify Name: ____________________

Route: ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC)

Total dose: ___________ ○ Weekly ○ Monthly

Dose unit: ___________ ○ unit/iu ○ mcg /mcgm/ µg

**ESA/EPO/Erythropoetin Primary Funding Source

○ Government funded → ○ Government centres ○ JPA reimbursed ○ Government subsidy ____________________

○ SOCSO

○ Zakat / Baitumal

○ NGO/Charity body funded → ○ Religious Group ○ Voluntary Group

○ Self funded

○ Employer subsidised

○ Insurance

○ Others, specify ____________________

**ESA/EPO/Erythropoetin Other Funding Source

☐ Government funded → ○ Government centres ○ JPA reimbursed ○ Government subsidy

☐ SOCSO

☐ Zakat / Baitumal

☐ NGO/Charity body funded → ○ Religious Group ○ Voluntary Group

☐ Self funded

☐ Employer subsidised

☐ Insurance

☐ Others, specify ____________________

For source of funding government other specify, only specify government sources and not all the others, i.e. not SOCSO, Zakat, Self funding, NGO, etc

PART 2 - A : MEDICATION

Renal Bone Treatment

☐ **Phosphate binder

Name: ______________________

Route: ○ Oral

☐ Calcitriol

Name: ______________________

Route: ○ Oral ○ Injection - Intravenous (IV)

☐ **Vitamin D

Name: ______________________

Route: ○ Oral ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC) ○ Injection - Intramuscular (IM)

☐ Calcimmetic (eg. Cinacalcet)

Name: ______________________

Route: ○ Oral ○ Injection - Intravenous (IV)

Anaemia Treatment

☐ **Iron therapy

Name: ______________________

Route: ○ Oral ○ Injection - Intravenous (IV)

☐ Hematinics

Name: ______________________

Route: ○ Oral ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC) ○ Injection - Intramuscular (IM)

Anti Hypertensive Treatment

☐ ACE Inhibitor

Name: ______________________

Route: ○ Oral

☐ Alpha Blocker

Name: ______________________

Route: ○ Oral

☐ ARB

Name: ______________________

Route: ○ Oral

☐ Beta Blocker

Name: ______________________

Route: ○ Oral

☐ Calcium Channel Blocker (CCB)

Name: ______________________

Route: ○ Oral

☐ Direct Renin Inhibitors (DRI)

Name: ______________________

Route: ○ Oral

☐ Other Anti Hypertensive Treatment

Name: ______________________

Route: ○ Oral

Lipid Lowering Treatment

☐ Cholesterol Absorption Inhibitor

Name: ______

Route: ○ Oral

☐ Fibrates (Fibric Acid Derivatives)

Name: ______

Route: ○ Oral

☐ Nicotinic Acid

Name: ______

Route: ○ Oral

☐ Resins (Bile-Acid Sequestrants)

Name:

Route: ○ Oral

☐ Statins (HMG-CoA reductase Inhibitors)

Name: ______

Route: ○ Oral

☐ Other Lipid Lowering Treatment

Name: ______

Route: ○ Oral

Diuretics

1. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV)
2. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV)
3. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV)
4. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV)
5. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV)

Other Drug Treatment

1. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC) ○ Injection - Intramuscular (IM)
2. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC) ○ Injection - Intramuscular (IM)
3. **Name:**
   Route: ○ Oral ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC) ○ Injection - Intramuscular (IM)
4. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC) ○ Injection - Intramuscular (IM)
5. **Name:** ______
   Route: ○ Oral ○ Injection - Intravenous (IV) ○ Injection - Subcutaneous (SC) ○ Injection - Intramuscular (IM)

PART 2 - B : THERAPY & EVENT

01. **Renal Bone Treatment	**a. Parathyroidectomy done in this year?**	○ Yes	○ No
	b. Deferoxamine therapy done in this year?	○ Yes	○ No
02. **Anemia Treatment	**a. Blood Transfusion in this year?**	○ Yes, Total No. Of Bags ________	○ No
	b. Did PRCA or other immunologenic adverse event occur this year?	○ Yes ↳ **Anti-erythropoietin (anti-EPO) antibodies result?** ○ Not done ○ Positive ○ Negative	○ No

PART 3 - A : VITAL SIGN

MEASUREMENT		**Systolic BP (mmHg)	**Diastolic BP (mmHg)	Weight (Kg) #	Ultrafiltration volume (Litre) #	Target Dry Weight (Kg) #
01. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
02. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
03. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
04. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
05. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
06. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
07. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
08. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
09. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
10. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
11. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					
12. Date ________ *(dd/mm/yyyy)*	Pre HD					
	Post HD					

PART 3 - B : DIALYSIS PERFORMANCE

URR Performed? Check if yes ☐

****URR measurement**
(*The measurement unit for pre & post the lab test must be done within the same day)

Date	*(dd/mm/yyyy)*	*(dd/mm/yyyy)*
Pre Urea*		
Post Urea*		
URR(%)		

Delivered KT/V performed? Check if yes ☐

****Delivered Kt/V measurement**
(Please select one technique only and try to use the same technique for the same patient)

Date	*(dd/mm/yyyy)*	*(dd/mm/yyyy)*
Technique #	○ UKM modeling Kt / V ○ Online modeling Kt / V ○ Others, specify ________________	○ UKM modeling Kt / V ○ Online modeling Kt / V ○ Others, specify ________________
KT/V result #		

PART 4 - A : Lab

**TESTS	Unit	Date: ____________	Date: ____________	Date: ____________	Date: ____________
01. Sr. Creatinine	µmol/L				
	mg/dL				
02. Uric Acid	µmol/L				
03. Plasma Urea	mmol/L				
	mg/dL				
04. Sr. Potassium	mmol/L				
05. Sr. Sodium #	mmol/L				
06. Sr. Albumin #	g/L				
	g/dL				
07. Bilirubin	µmol/L				
08. Sr. Calcium	mmol/L				
	mg/dL				
09. Sr. Uncorrected Calcium #	mmol/L				
10. Sr. Phosphate #	mmol/L				
	mg/dL				
11. Sr. Alkaline Phosphatase (ALP)	U/L				
12. ALT / SGPT	U/L				
13. AST / SGOT	U/L				
14. Hb #	g / dL				
15. TWBC	µl				
16. Hypochromic cells	%				
17. PLT (Platelet count)	10^9 / L				
18. FBS	mmol/L				
	mg/dL				
19. Protein	g/L				
20. HbA1C	%				
21. Sr. Iron	µmol/L				
	µg/dL				
22. Sr. UIBC	µmol/L				
	µg/dL				
23. Sr. TIBC (Auto Calc)	µmol/L				
24. Sr. TIBC (Manual)	µmol/L				
25. Sr. TSAT (Auto Calc)	%				
26. Sr. TSAT (Manual)	%				
27. Sr. Ferritin #	µg/L				
	pmol/L				
28. Sr. Cholesterol	mmol/L				
	mg/dL				
29. Sr. Triglyceride (Fasting)	mmol/L				
	mg/dL				

PART 4 - A : Lab (Con't)

TESTS	Unit	Date: ________	Date: ________	Date: ________	Date: ________
30. LDL	mmol/L				
	mg/dL				
31. HDL	mmol/L				
	mg/dL				
32. Intact PTH	pg/mL				
	pmol/L				
33. CRP	mg/dL				
34. Sr. Aluminium	µg/L				
	µmol/L				
35. LY # (Lymphocyte Count)	HSD/CU mm				

PART 4 - B : Serology

SEROLOGY TEST	**Date: ________			**Date: ________			**Date: ________			**Date: ________		
	Positive	Negative	Not Done	Positive	Negative	Not Done	Positive	Negative	Not Done	Positive	Negative	Not Done
01. **Hep B antigen (HBsAg)	○	○	○	○	○	○	○	○	○	○	○	○
03. **Hep B antibody (HBsAb)	○	○	○	○	○	○	○	○	○	○	○	○
If positive, specify (IU/ml)	________ IU/ml			________ IU/ml			________ IU/ml			IU/ml		
04. Hep B Core antibody (HBcAb) (If available)	○	○	○	○	○	○	○	○	○	○	○	○
05. **Anti HCV antibody	○	○	○	○	○	○	○	○	○	○	○	○
06. **Anti HIV antibody	○	○	○	○	○	○	○	○	○	○	○	○
07. CMV - IgG	○	○	○	○	○	○	○	○	○	○	○	○
08. CMV - IgM	○	○	○	○	○	○	○	○	○	○	○	○
09. EBV - IgG	○	○	○	○	○	○	○	○	○	○	○	○
10. EBV - IgM	○	○	○	○	○	○	○	○	○	○	○	○

Hospitalization

Is there any hospitalization this year? ○ Yes ○ No

01. **Date of Admission: ________________ **02. Date of Discharge:** ________________

03. **Definitive Diagnosis of Admission

- ☐ **Infections**
- ☐ **Cardiovascular Event**
  - ☐ **Myocardial Infarction**
  - ☐ **Heart Failure**
  - ☐ **Others, specify** ________________
- ☐ **Fluid Overload**
- ☐ **Cerebrovascular Event**
  - ☐ **Stroke**
- ☐ **Uremia Related**
- ☐ **Others, specify** ________________

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  - ☐ **Heart Failure**
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  - ☐ **Stroke**
- ☐ **Uremia Related**
- ☐ **Others, specify** ________________