

RENAL TRANSPLANT PATIENT NOTIFICATION

(Complete this form to notify dialysis patient to NRR. You must notify all patients in your centre.)

Office use:

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

Centre:

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PART 1 : PATIENT INFO

** - Compulsory

01. ** Reporting centre			
02. Modality of the centre			
03. ** Name & Title			
04. ** Identification card number:	My NRIC		Old IC No
	Other document No		Document type
05. ** Date of Birth	(dd/mm/yyyy)		
06. ** Gender	<input type="radio"/> Male <input type="radio"/> Female		
07. ** ABO Blood group	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> AB <input type="radio"/> O		
08. ** Centre Type	<input type="radio"/> Regular Follow-up <input type="radio"/> Medication only		
09. Treatment courses	<i>Where date is requested, write as dd/mm/yyyy. If exact date is unknown, an estimate will do, eg end 1985, mid 1994.</i>		
	a. **Date started Post Transplant follow up at your centre	(dd/mm/yyyy)	
	b. **Date Transplant	(dd/mm/yyyy)	
	c. Name of Transplant Nephrologist		
	d. Name of transplant surgeon		
e. Description of transplant details:			
10. ** Place of transplant centre	<input type="radio"/> HKL	<input type="radio"/> Prince Court Medical Centre	<input type="radio"/> Gleneagles Intan Medical Centre
	<input type="radio"/> Selayang Hospital	<input type="radio"/> HUKM	<input type="radio"/> Selangor Medical Centre
	<input type="radio"/> UMMC	<input type="radio"/> SJMC	<input type="radio"/> Tawakal Hospital
	<input type="radio"/> Sunway Medical	<input type="radio"/> PPUiTM	
	<input type="radio"/> Other local transplant place, specify		
	<input type="radio"/> Other overseas transplant place, specify		
11. Kidney Graft number			
12. Age Started at your centre			
13. ** Date started dialysis after onset of ESRF / Pre-emptive transplant	<input type="radio"/> Date started dialysis after onset of ESRF _____ (dd/mm/yyyy)		
	<input type="radio"/> Pre-emptive transplant		

PART 2 : CONTACT INFO

01. Address	
02. ** Postcode	03. ** Town / City
04. ** State	
05. ** Country	
06. ** Contact number	Homephone
	Handphone tel
	Work telephone Extension
	Fax

PART 3 : DEMOGRAPHICS

01. ** Citizenship	<input type="radio"/> Malaysian	<input type="radio"/> Foreigner, Country of Origin _____
02. ** Ethnic group	<input type="radio"/> Malay <input type="radio"/> Bumiputra Sabah <input type="radio"/> Other Malaysian _____	<input type="radio"/> Chinese <input type="radio"/> Bumiputra Sarawak <input type="radio"/> Indian <input type="radio"/> Orang Asli Semenanjung
03. ** Marital Status	<input type="radio"/> Single <input type="radio"/> Divorced	<input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Widowed
04. ** Highest Education	<input type="radio"/> No formal education <input type="radio"/> Tertiary	<input type="radio"/> Primary <input type="radio"/> Secondary
05. ** Family Income / month	<input type="radio"/> < RM 1,000 <input type="radio"/> RM 5,001 - 10,000	<input type="radio"/> RM 1,000 - 3,000 <input type="radio"/> > RM 10,000 <input type="radio"/> RM 3,001 - 5,000
06. Current Occupation	<input type="radio"/> Agricultural / Fishery / Forestry <input type="radio"/> Homemaker / Housewife <input type="radio"/> Professional / Technical / Manager <input type="radio"/> Others, specify _____	<input type="radio"/> Clerical / Sales <input type="radio"/> Military / Police / Fireman <input type="radio"/> Service <input type="radio"/> Factory Worker <input type="radio"/> Own Business <input type="radio"/> Student
07. ** Cigarette smoker	<input type="radio"/> Never	<input type="radio"/> Former <input type="radio"/> Current

PART 4 : CLINICAL DIAGNOSIS

Primary Renal Disease

- Glomerulonephritis, specify
If patient has Glomerulonephritis, kindly fill up the Glomerulonephritis section on Page 3
- Obstructive uropathy, specify
- Hereditary nephritis, specify
- Others, specify
- Diabetes Mellitus
If patient has Diabetes Mellitus, kindly fill up the Diabetes Mellitus section on Page 3
- ADPKD
- CAKUT
- Hypertension
If patient has Hypertension, kindly fill up the Hypertension section on Page 3
- Drugs / toxic nephropathy
- Unknown

Specify details: _____

PART 5 : CO-MORBIDITIES

01. ** Date of Diagnosis	02. Date Resolve (if applicable)	03. ** Comorbidity
		<input type="checkbox"/> Cardiovascular disease, specify _____ <div style="border: 1px solid black; padding: 5px; margin-left: 20px;"> <input type="checkbox"/> Congestive cardiac failure → History of Heart Failure? _____ <input type="checkbox"/> Ischaemic heart disease → History of Acute myocardial infarction? _____ <input type="checkbox"/> Other cardiac disorder, specify: _____ </div>
		<input type="checkbox"/> Diabetes mellitus <i>If patient has Diabetes mellitus, kindly fill up the Diabetes mellitus section on Page 3</i>
		<input type="checkbox"/> Hypertension, requiring treatment <i>If patient has Hypertension, kindly fill up the Hypertension section on Page 3</i>
		<input type="checkbox"/> Cerebrovascular disorder → History of Stroke? <input type="radio"/> Yes <input type="radio"/> No
		<input type="checkbox"/> Chronic respiratory disorder, specify _____
		<input type="checkbox"/> Chronic liver disorder, specify _____
		<input type="checkbox"/> Gastrointestinal disorder, specify _____
		<input type="checkbox"/> Peripheral vascular disorder
		<input type="checkbox"/> Cancer, specify _____
		<input type="checkbox"/> Dementia
		<input type="checkbox"/> ESRD
		<input type="checkbox"/> Peptic ulcer disease
		<input type="checkbox"/> Renal bone disease - Biochemical
		<input type="checkbox"/> Psychiatric disorder, specify _____
		<input type="checkbox"/> Non accidental limb amputation due to vascular disorder
		<input type="checkbox"/> TB (any site)
		<input type="checkbox"/> Other co-morbidity, specify: _____
		<input type="checkbox"/> Glomerulonephritis, specify _____ <i>If patient has Glomerulonephritis, kindly fill up the Glomerulonephritis section on Page 3</i>
		<input type="checkbox"/> Obstructive uropathy, specify _____
		<input type="checkbox"/> Hereditary nephritis, specify _____
		<input type="checkbox"/> ADPKD
		<input type="checkbox"/> CAKUT
		<input type="checkbox"/> Drugs / toxic nephropathy
		<input type="checkbox"/> Renal bone disease - parathyroidectomy
		<input type="checkbox"/> Renal bone disease - X-ray evidence

DIABETES MELLITUS

- Diabetic nephropathy in type I diabetes - histologically
- Diabetic nephropathy in type II diabetes - histologically
- Diabetic Unknown histology
- Diabetic nephropathy in type I diabetes - no histology
- Diabetic nephropathy in type II diabetes - no histology

HYPERTENSION

- Chronic hypertensive nephropathy - histologically proven
- Chronic hypertensive nephropathy - no histology
- Hypertension Unknown histology

GLOMERULONEPHRITIS

<input type="checkbox"/> Report not conclusive	<input type="radio"/> No / not enough glomeruli <input type="radio"/> Others, specify: _____																																																																
<input type="checkbox"/> Primary GN	<input type="radio"/> Minimal Change <input type="radio"/> FSGS → <table border="1" style="display: inline-table; margin-left: 20px;"> <tr> <td><input type="radio"/> Tip lesion</td> <td><input type="radio"/> Cellular</td> <td><input type="radio"/> Collapsing</td> <td><input type="radio"/> Peri-hilar</td> </tr> <tr> <td colspan="4"><input type="radio"/> Not otherwise specified _____</td> </tr> </table> <input type="radio"/> Ig A nephropathy → <table border="1" style="display: inline-table; margin-left: 20px;"> <tr> <td><input type="radio"/> Minimal change</td> <td><input type="radio"/> Focal proliferative</td> <td><input type="radio"/> Advanced chronic GN</td> </tr> <tr> <td><input type="radio"/> FSGS-like</td> <td><input type="radio"/> Diffuse proliferative</td> <td></td> </tr> </table> <input type="radio"/> Membranous nephropathy <input type="radio"/> Membrano-proliferative <input type="radio"/> Mesangial Proliferative GN-non IgA <input type="radio"/> Crescentic ANCA <input type="radio"/> Idiopathic Crescentic GN	<input type="radio"/> Tip lesion	<input type="radio"/> Cellular	<input type="radio"/> Collapsing	<input type="radio"/> Peri-hilar	<input type="radio"/> Not otherwise specified _____				<input type="radio"/> Minimal change	<input type="radio"/> Focal proliferative	<input type="radio"/> Advanced chronic GN	<input type="radio"/> FSGS-like	<input type="radio"/> Diffuse proliferative																																																			
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<input type="checkbox"/> Secondary GN	<input type="radio"/> Hensch Schonlein Purpura → <table border="1" style="display: inline-table; margin-left: 20px;"> <tr> <td><input type="radio"/> Grade I - Minimal glomerular disease</td> <td><input type="radio"/> Grade IV - 50-75% Crescent</td> </tr> <tr> <td><input type="radio"/> Grade II - Mesangial proliferative</td> <td><input type="radio"/> Grade V - >75% Crescent</td> </tr> <tr> <td><input type="radio"/> Grade III - Focal and segmental Glomerulonephritis or Diffuse proliferative < 50%</td> <td><input type="radio"/> Grade VI - Membrano-proliferative</td> </tr> </table> <input type="radio"/> HUS / TTP <input type="radio"/> Anti GBM disease <input style="width: 50px;" type="text"/> % Crescent <input type="radio"/> Diabetic nephropathy <input type="radio"/> Amyloidosis <input type="radio"/> Systemic vasculitis <input type="radio"/> Post Infectious GN → <table border="1" style="display: inline-table; margin-left: 20px;"> <tr> <td><input type="checkbox"/> Crescentic → <input style="width: 50px;" type="text"/> % Crescent</td> <td><input type="checkbox"/> Mesangial-proliferative</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Endocapillary</td> </tr> </table> <input type="radio"/> Other infection <table style="margin-left: 20px;"> <tr> <td><input type="radio"/> Hepatitis B →</td> <td><table border="1" style="display: inline-table;"> <tr> <td><input type="radio"/> Minimal change</td> <td><input type="radio"/> Membranous nephropathy</td> </tr> <tr> <td><input type="radio"/> FSGS</td> <td><input type="radio"/> Membrano- proliferative</td> </tr> </table> </td> </tr> <tr> <td><input type="radio"/> Hepatitis C →</td> <td><table border="1" style="display: inline-table;"> <tr> <td><input type="radio"/> Minimal change</td> <td><input type="radio"/> Membranous nephropathy</td> </tr> <tr> <td><input type="radio"/> FSGS</td> <td><input type="radio"/> Membrano- proliferative</td> </tr> </table> </td> </tr> <tr> <td><input type="radio"/> HIV →</td> <td><table border="1" style="display: inline-table;"> <tr> <td><input type="radio"/> Collapsing</td> <td><input type="radio"/> Lupus like</td> <td><input type="radio"/> TTP like</td> </tr> <tr> <td colspan="3"><input type="radio"/> Others, specify: _____</td> </tr> </table> </td> </tr> </table> <input type="radio"/> Polyarteritis Nodosa <input style="width: 50px;" type="text"/> % Crescent <input type="radio"/> Malignancy → <table border="1" style="display: inline-table; margin-left: 20px;"> <tr> <td><input type="radio"/> Membranous nephropathy</td> <td><input type="radio"/> Membrano- proliferative</td> <td><input type="radio"/> Minimal change</td> </tr> </table> <input type="radio"/> Multiple myeloma <input type="radio"/> Immunotactoid / fibrillary GN <input type="radio"/> Light / Heavy chain deposit disease <input type="radio"/> Lupus Nephritis → <table border="1" style="display: inline-table; margin-left: 20px;"> <tr> <td><input type="radio"/> WHO Class</td> <td><input type="radio"/> ISN / RPS Class</td> <td>→ <input style="width: 50px;" type="text"/> % Crescent</td> </tr> <tr> <td colspan="3" style="text-align: center;">↓</td> </tr> <tr> <td><table border="1" style="display: inline-table;"> <tr> <td><input type="radio"/> Class I</td> <td><input type="radio"/> Class IV</td> </tr> <tr> <td><input type="radio"/> Class II</td> <td><input type="radio"/> Class IV + V</td> </tr> <tr> <td><input type="radio"/> Class II + V</td> <td><input type="radio"/> Class V</td> </tr> <tr> <td><input type="radio"/> Class III</td> <td><input type="radio"/> Class VI</td> </tr> <tr> <td><input type="radio"/> Class III + V</td> <td><input type="radio"/> Others</td> </tr> </table> </td> <td>→</td> <td><table border="1" style="display: inline-table;"> <thead> <tr> <th>^Subclass ISN III</th> <th colspan="2">^^Subclass ISN IV</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/> A</td> <td><input type="radio"/> S(A)</td> <td><input type="radio"/> G(A)</td> </tr> <tr> <td><input type="radio"/> A/C</td> <td><input type="radio"/> S(A/C)</td> <td><input type="radio"/> G(A/C)</td> </tr> <tr> <td><input type="radio"/> C</td> <td><input type="radio"/> S(C)</td> <td><input type="radio"/> G(C)</td> </tr> </tbody> </table> </td> </tr> </table>	<input type="radio"/> Grade I - 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<input type="checkbox"/> Hereditary	<input type="radio"/> Alport's syndrome <input type="radio"/> Thin Basement Membrane disease <input type="radio"/> Other, specify: _____																																																																
<input type="checkbox"/> Advance GN																																																																	
<input type="checkbox"/> Others																																																																	

PART 6 : MEDICATION TREATMENT

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

Immunosuppressive Drug Treatment - Induction

Anti IL2R Antibodies

Name: _____

Route: Injection - Intravenous (IV)

Methylprednisolone

Name: _____

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

Monoclonal antibodies

Name: _____

Route: Injection - Intravenous (IV)

Polyclonal antibodies

Name: _____

Route: Injection - Intravenous (IV)

Other Induction Immunosuppressive Drug

Name: _____

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

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 7 : DONOR DETAILS

01. ** Type of donor	<input type="radio"/> Cadaveric <input type="radio"/> Living donor		
02. Donor Name			
03. Donor My NRIC			
04. Age			
05. Gender	<input type="radio"/> Male <input type="radio"/> Female		
06. i. Height	(cm)	ii. Weight	(kg)
07. Ethnic Group	<input type="radio"/> Malay <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Bumiputra Sabah <input type="radio"/> Bumiputra Sarawak <input type="radio"/> Orang Asli Semenanjung <input type="radio"/> Other Malaysian _____ <input type="radio"/> Other foreigner _____		
08. Donor's Parameters	<p><i>If Donor type is Cadaveric, kindly complete:</i></p> <div style="border: 1px solid black; padding: 5px;"> <p>a. Deceased donor type <input type="checkbox"/> Brain Death → Preop Inotropes <input type="radio"/> Yes <input type="radio"/> No</p> <p> <input type="checkbox"/> Non-heart Beating → <input type="checkbox"/> Head Injury <input type="checkbox"/> CVA</p> <p> <input type="checkbox"/> Others, specify _____</p> </div> <p>b. Cause of death <input type="checkbox"/> Head Injury <input type="checkbox"/> CVA <input type="checkbox"/> Others, specify _____</p> <p>c. Date time of death _____ (dd/mm/yyyy)</p> <p>d. Date time of procurement _____ (dd/mm/yyyy)</p> <p>e. Multiorgan Harvesting <input type="radio"/> Yes <input type="radio"/> No</p> <p>f. Creatinine _____ (umol/L)</p> <p>g. Procurement centre _____</p> <p><i>If Donor type is Living Donor, kindly complete:</i></p> <div style="border: 1px solid black; padding: 5px;"> <p>a. Living donor type <input type="radio"/> Related → <input type="radio"/> Genetically related</p> <div style="border: 1px solid black; padding: 5px; margin-left: 20px;"> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Daughter <input type="radio"/> Son <input type="radio"/> Monozygotic twin <input type="radio"/> Dizygotic twin <input type="radio"/> Others _____ </div> <p><input type="radio"/> Emotional</p> <div style="border: 1px solid black; padding: 5px; margin-left: 20px;"> <input type="radio"/> Wife <input type="radio"/> Husband <input type="radio"/> Others _____ </div> </div> <p><input type="radio"/> Unrelated</p> <p>b. Creatinine _____ (umol/L)</p> <p>c. Creatinine clearance _____ (ml/min)</p> <p>d. GFR (DTPA) Left _____ (ml/min) Right _____ (ml/min)</p> <p>e. GFR (EDTA) Left _____ (ml/min) Right _____ (ml/min)</p>		

PART 8 : RECIPIENT - DONOR MATCH DATA

01. HLA Mismatch

HLA	Recipient		Donor	
	Value 1	Value 2	Value 1	Value 2
HLA-A				
HLA-B				
HLA-C				
HLA-DQ				
HLA-DR				

PART 8 : RECIPIENT - DONOR MATCH DATA

02. Cross match

i. Microlymphocytotoxicity	a. CDC Standard	<input type="radio"/> Positive	<input type="radio"/> Negative	<input type="radio"/> Not done	
	b. DTT treated CDC	<input type="radio"/> Positive	<input type="radio"/> Negative	<input type="radio"/> Not done	
	c. AHG treated CDC	<input type="radio"/> Positive	<input type="radio"/> Negative	<input type="radio"/> Not done	
ii. Flow Cytometry	<input type="radio"/> Positive, specify Channel Shift _____		<input type="radio"/> Negative	<input type="radio"/> Not done	
iii. Anti HLA Antibody	a. Class 1	<input type="radio"/> Positive, specify % _____	<input type="radio"/> Negative	<input type="radio"/> Not done	
	b. Class 2	<input type="radio"/> Positive, specify % _____	<input type="radio"/> Negative	<input type="radio"/> Not done	
	c.				
		HLA	Donor	DSA	
		HLA-A Value 1		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-A Value 2		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-B Value 1		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-B Value 2		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-C Value 1		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-C Value 2		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-DQ Value 1		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-DQ Value 2		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-DR Value 1		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		HLA-DR Value 2		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
		_____ Value 1		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done
	_____ Value 2		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done	
	_____ Value 1		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done	
	_____ Value 2		<input type="radio"/> Positive, MFA _____	<input type="radio"/> Negative <input type="radio"/> Not done	

PART 9 : RECIPIENT - DONOR SEROLOGY

	Recipient	Donor
01. Blood Group	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> AB <input type="radio"/> O	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> AB <input type="radio"/> O
02. Serology		
i. Lab date	_____ (dd/mm/yyyy)	_____ (dd/mm/yyyy)
ii.		
a. Hep B antigen (HBsAg)	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
a. HBeAg, if HBsAg is Positive	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
b. Hep B antibody (HBsAb)	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done If positive, specify _____ IU/ml	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done If positive, specify _____ IU/ml
c. Anti HCV antibody	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
d. Anti HIV antibody	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
e. Hep B Core antibody (HBcAb)	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
f. CMV - IgG	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
g. CMV - IgM	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
h. EBV - IgG	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
i. EBV - IgM	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
j. HSV - IgG	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
k. RPR-VDRL	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done

PART 10 : TRANSPLANT SURGERY DATA

01. Ischaemic time	Cold Hours _____ Minutes _____ Warm Hours _____ Minutes _____ Total Ischaemic time Hours _____
02. Donor Kidney	<input type="radio"/> Left <input type="radio"/> Right
03. Artery	a. Recipient <input type="checkbox"/> External iliac <input type="checkbox"/> Common iliac <input type="checkbox"/> Internal iliac <input type="checkbox"/> Others, specify _____
	b. Anastomosis <input type="checkbox"/> End-to-Side <input type="checkbox"/> End-to-End
	c. Donor Artery Supply <input type="radio"/> Single <input type="radio"/> Double <input type="radio"/> Multiple Comment _____
04. Vein	<input type="checkbox"/> External iliac <input type="checkbox"/> Internal iliac <input type="checkbox"/> Common iliac <input type="checkbox"/> Others, specify _____
05. Ureter	<input type="radio"/> Intravesical <input type="radio"/> Extra vesical
06. Stent	<input type="radio"/> Yes <input type="radio"/> No
07. Surgical Comment	

PART 11 : IMMEDIATE POST TRANSPLANT DATA

01. Graft function	<input type="radio"/> Immediate <input type="radio"/> Delayed <input type="radio"/> Non-function
02. a. Surgical Complications	<input type="checkbox"/> Renal artery thrombosis <input type="checkbox"/> Lymphocele <input type="checkbox"/> Others, specify _____
	<input type="checkbox"/> Renal vein thrombosis <input type="checkbox"/> Haemorrhage requiring operation <input type="checkbox"/> None
b. Urological Complications	<input type="checkbox"/> Urinary tract leak / Urinoma <input type="checkbox"/> Ureteric obstruction / urinary tract stenosis <input type="checkbox"/> Others, specify _____ <input type="checkbox"/> None
c. Management	<input type="checkbox"/> Conservative / observation <input type="checkbox"/> Surgical intervention _____ <input type="checkbox"/> Outcome of Management _____ <input type="checkbox"/> None