

RENAL TRANSPLANT ANNUAL RETURN

Please complete this form for each renal transplant patient on follow-up at your centre for the year

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

Name	Hj/Hjh/Dato'/Dr.		
NRR Registration Number	Patient ID:		RRTID:
	<i>Nota: Jika pesakit tiada nombor pendaftaran NRR, tolong isikan borang 'Renal Transplant Notification' dan pulang bersama borang ini.</i>		
Centre name			SDPID:

SECTION 1 : MEDICATION (check one or more boxes below if present)

1. Immunosuppressive drug(s) treatment: <input type="checkbox"/> a. Prednisolone <input type="checkbox"/> b. Calcineurin inhibitors <input type="checkbox"/> Cyclosporin <input type="checkbox"/> Neoral <input type="checkbox"/> Sandimmune <input type="checkbox"/> Gengraf <input type="checkbox"/> Others, specify : <input type="checkbox"/> c. Antimetabolites <input type="checkbox"/> Azathioprine <input type="checkbox"/> Mycophenolic acid → <input type="checkbox"/> Others, specify : <input type="checkbox"/> Mycophenolate Mofetil (Cellcept) <input type="checkbox"/> Mycophenolate Sodium (Myfortic) <input type="checkbox"/> Others, specify : <input type="checkbox"/> d. mTOR inhibitors <input type="checkbox"/> Sirolimus / Rapamycin <input type="checkbox"/> Everolimus <input type="checkbox"/> Others, specify : <input type="checkbox"/> e. Others, specify :	2. Anti-hypertensive treatment: <input type="checkbox"/> a. Alpha blockers (Prazosin) <input type="checkbox"/> b. ACE inhibitor <input type="checkbox"/> c. Angiotensin II receptor blockers (ARBs) <input type="checkbox"/> d. Beta blockers <input type="checkbox"/> e. Calcium channel blockers <input type="checkbox"/> f. Direct Renin Inhibitors (DRI) <input type="checkbox"/> g. Other, specify :
3. Lipid lowering treatment a. Statins (HMG-CoA reductase Inhibitors) <input type="checkbox"/> Lovastatin <input type="checkbox"/> Atorvastatin (Lipitor) <input type="checkbox"/> Others, specify : <input type="checkbox"/> Pravastatin <input type="checkbox"/> Rosuvastatin <input type="checkbox"/> Simvastatin (Zocor) <input type="checkbox"/> Fluvastatin b. Fibrates (Fibric-Acid Derivatives) <input type="checkbox"/> Bezafibrate <input type="checkbox"/> Fenofibrate <input type="checkbox"/> Others, specify : <input type="checkbox"/> Ciprofibrate <input type="checkbox"/> Gemfibrozil	c. Resins (Bile-Acid Sequestrants) <input type="checkbox"/> Cholestyramine <input type="checkbox"/> Others, specify : d. Nicotinic Acid (Nicotinic Acid) <input type="checkbox"/> Nicotinic acid (Niacin) <input type="checkbox"/> Others, specify : <input type="checkbox"/> Acipimox (Olbetam) e. Cholesterol Absorption Inhibitors <input type="checkbox"/> Ezetimibe (Zetia, Ezetrol) <input type="checkbox"/> Others, specify :

SECTION 2 : LABORATORY DATA (Please enter the value into the appropriate box according to the lab test unit)

Record the following test results for the last year at about 3 monthly interval. Please delete the appropriate unit of measurement (SI / traditional).

TESTS	UNITS	X 1	X 2	X 3	X 4
Sr. Creatinine	μmol/L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	mg/dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hb	g / dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sr. Albumin	g / L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	g / dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sr. Calcium	mmol/L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	mg/dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sr. Phosphate	mmol/L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	mg/dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sr. Alkaline Phosphatase (ALP)	U / L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ALAT / SGPT	U / L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sr. Cholesterol	mmol/L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	mg/dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sr. Triglyceride (Fasting)	mmol/L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	mg/dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LDL	mmol/L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	mg/dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HDL	mmol/L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	mg/dL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SEROLOGICAL TESTS :	Positive	Negative	Not done
1. Hep. B antigen (HBsAg)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hep. B antibody (HBsAb)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Anti-HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 3 : OBSERVATION

1. Patient Yearly Height :

. cm

2. Blood Pressure Weight (Record the values at routine clinic follow-up)

	X1	X2	X3	X4
Systolic BP (mmHg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diastolic BP (mmHg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Weight (Kg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION 4 : POST TRANSPLANT COMPLICATIONS (occurred in this year only)

1. Diabetes :	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Cancer :	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes → Specify :
3. Cardiovascular disease:	<input type="checkbox"/> Yes — If Yes → a. <input type="checkbox"/> Coronary b. <input type="checkbox"/> Non Coronary c. <input type="checkbox"/> CVA <input type="checkbox"/> No
4. Decompensated liver disease:	<input type="checkbox"/> Yes — If Yes → a. <input type="checkbox"/> Hep B c. <input type="checkbox"/> Hep C <input type="checkbox"/> No (Cause please) b. <input type="checkbox"/> Drug, specify d. <input type="checkbox"/> Others, specify
5. Infection	Pneumocystis pneumonia (PCP) <input type="checkbox"/> Yes <input type="checkbox"/> No CMV infection <input type="checkbox"/> Yes <input type="checkbox"/> No Others, specify
6. Surgical :	Renal artery stenosis <input type="checkbox"/> Yes <input type="checkbox"/> No Obstructive uropathy → <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes → Specify : Others, specify

SECTION 5 : ACUTE REJECTION INCIDENT REPORTING (occurred in this year only)

1. Acute Rejection

i.) Date (dd/mm/yy):

ii.) Biopsy performed — If Yes → Type of rejection a) Cell mediated rejection
 No Biopsy b) Antibody mediated rejection

iii.) Treatment given: (Intervention code & specify) a) b) c) Specify :

iv.) Outcome:
 Respond (Cr back to baseline) Rescue therapy: (Intervention code & specify) a) b) c)
 Partial Respond — If Yes → Specify :
 No Respond — If Yes →

INTERVENTION CODE	CODE
No treatment	1
Immunoglobulin	2
Methylprednisolone	3
Thymoglobuline	4
Orthoclone OKT3	5
Plasmapheresis	6
Double Filtration on Plasmapheresis	601
Plasma Exchange	602
Immuno-absorption	603
Surgical intervention	7
Haemodialysis	8
Re-adjust immunosuppressive	9
Others, specify	999
Not available	8888

2. Acute Rejection

i.) Date (dd/mm/yy):

ii.) Biopsy performed — If Yes → Type of rejection a) Cell mediated rejection
 No Biopsy b) Antibody mediated rejection

iii.) Treatment given: (Intervention code & specify) a) b) c) Specify :

iv.) Outcome:
 Respond (Cr back to baseline) Rescue therapy: (Intervention code & specify) a) b) c)
 Partial Respond — If Yes → Specify :
 No Respond — If Yes →

3. Acute Rejection

i.) Date (dd/mm/yy):

ii.) Biopsy performed — If Yes → Type of rejection a) Cell mediated rejection
 No Biopsy b) Antibody mediated rejection

iii.) Treatment given: (Intervention code & specify) a) b) c) Specify :

iv.) Outcome:
 Respond (Cr back to baseline) Rescue therapy: (Intervention code & specify) a) b) c)
 Partial Respond — If Yes → Specify :
 No Respond — If Yes →