

RENAL TRANSPLANT NOTIFICATION

NRR ID: /

SDPID:

Instruction: Complete this form to notify renal transplant patient in your centre within one month after the first visit of the patient.

Where check boxes are provided, 1) check one or more boxes 2) check one box only

Name of reporting centre: _____

Date follow-up at your clinic / centre: dd mm yyyy

Name of transplant centre: _____

Date of Transplant: dd mm yyyy

Place of transplant centre: Local China India Others, specify: _____

Kidney Graft Number:

SECTION 1 : RECIPIENT DETAILS

1. Name: _____

2. Identification card number: MyKad / MyKid: - - Old:
Other document No: Specify document type:

3. Town/City: _____ State: _____

4. Contact number: Home: _____ H/P: _____ Work: _____ Ext: _____

5. Date of birth (dd/mm/yyyy): 6. Gender: M F 7. a) Weight (kg): b. Height (cm):

8. Citizenship: Malaysian Foreigner, specify: _____ Specify details : _____
Ethnic group: (Specify details in box)
 Malay Bumiputra Sarawak, specify: _____
 Chinese Bumiputra Sabah, specify: _____
 Indian Other Malaysian, specify: _____

9. Current or previous Occupation: _____

10. Marital Status: Single Widowed Married Divorced
11. Highest education attained: Uneducated Secondary Primary Tertiary
12. Family Income / month: < RM 1000 RM 1000 - 3000 RM 3001 - 5000 RM 5001 - 10000 > RM 10000
13. Cig. smoker: Never Former Current

14. Primary renal disease(s): (Please specify details in text box)

Glomerulonephritis specify: _____ Obstructive uropathy specify: _____ Hereditary nephritis specify: _____ Specify details : _____
 Diabetes Mellitus ADPKD Unknown
 Hypertension Drugs / toxic nephropathy Others, specify: _____

15. Co-morbid condition present :

Diabetes mellitus Respiratory disorder, specify: _____ Renal bone disease Biochemical
 Hypertension, requiring treatment Liver disorder, specify: _____ X-ray evidence
 Cardiovascular disease Cancer, specify: _____ Other co-morbidity, specify: _____ Parathyroidectomy
 Cerebrovascular disorder
 TB (any site)
 Peptic ulcer disease

16. Bone parameters (before transplant):

Biochemical parameters	Unit	Recipient
a. Calcium	mmol/L	
b. Phosphate	mmol/L	
c. ALP	U/L	
d. iPTH	pmol/L	
e. Serum albumin	g/L	

17. i) Date started dialysis after onset of ESRF (dd/mm/yyyy): ii) Pre-emptive transplant

18. Immunosuppressive drug(s) treatment:

i) Induction
 a. Methylprednisolone
 b. Anti IL2R Antibodies _____
 c. Polyclonal antibodies
 Anti-thymocyte globulin (ATG)
 Anti-lymphocyte globulin (ALG)
 Others, specify : _____
 d. Monoclonal antibodies
 e. Others, specify: _____

ii) Maintenance
 a. Prednisolone
 b. Calcineurin inhibitors
 Cyclosporin → Neoral Sandimmune
 Tacrolimus (FK506) → Gengraf Others, specify _____
 Others, specify : _____
 c. Antimetabolites
 Azathioprine → Mycophenolate Mofetil (Cellcept)
 Mycophenolic acid → Mycophenolate Sodium (Myfortic)
 Others, specify _____
 d. mTOR inhibitors
 Sirolimus / Rapamycin
 Everolimus
 Others, specify : _____
 e. Others, specify : _____

SECTION 2 : DONOR DETAILS

19. Age:		20. Gender:	<input type="radio"/> Male <input type="radio"/> Female	21. a) Weight (kg):		b. Height (cm):	
22. Ethnic group: (Specify details in box)	<input type="radio"/> Malay <input type="radio"/> Bumiputra Sarawak, specify: <input type="radio"/> Foreigner, specify: <input type="text"/>		<input type="radio"/> Chinese <input type="radio"/> Bumiputra Sabah, specify: <input type="text"/>		<input type="radio"/> Indian <input type="radio"/> Other Malaysian, specify: <input type="text"/>		
23. Type of donor:	<input type="radio"/> Deceased donor		OR		<input type="radio"/> Living donor		
24. Donor's parameters:				a. Living donor type			
a. Deceased donor type <input type="checkbox"/> Brain Death <input type="checkbox"/> Non-heart Beating				<input type="radio"/> Related <input type="radio"/> Unrelated			
Preop Inotropes: <input type="radio"/> Yes <input type="radio"/> No				<input type="radio"/> Genetically related <input type="radio"/> Emotional			
Cause of death: <input type="checkbox"/> Head injury <input type="checkbox"/> CVA <input type="checkbox"/> Others: _____				<input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Wife <input type="radio"/> Daughter <input type="radio"/> Son <input type="radio"/> Husband <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other, specify: _____ <input type="radio"/> Monozygotic twin <input type="radio"/> Dizygotic twin <input type="radio"/> Other specify: _____			
b. Date & Time of death:				b. Creatinine (µmol/L):			
<input type="text"/> / <input type="text"/> / <input type="text"/> & <input type="text"/> : <input type="text"/> <small>dd mm yyyy hh mm</small>				<input type="text"/>			
c. Date & Time of procurement:				c. Creatinine clearance (ml/min):			
<input type="text"/> / <input type="text"/> / <input type="text"/> & <input type="text"/> : <input type="text"/> <small>dd mm yyyy hh mm</small>				<input type="text"/>			
d. Multiorgan Harvesting: <input type="radio"/> Yes <input type="radio"/> No				d. GFR (DTPA) (ml/min):			
e. Creatinine (µmol/L): <input type="text"/>				Left: <input type="text"/> Right: <input type="text"/>			
f. Procurement centre: <input type="text"/>				e. GFR (EDTA) (ml/min):			
				Left: <input type="text"/> Right: <input type="text"/>			

SECTION 3 : RECIPIENT - DONOR MATCH DATA

25. HLA Mismatch	<input type="radio"/> 6 <input type="radio"/> 5 <input type="radio"/> 4 <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1 <input type="radio"/> 0																																																																																																																					
26. Panel Reactive Antibody?	<input type="radio"/> _____ (%) <input type="radio"/> Not done																																																																																																																					
27. Lymphocyte cross-match	<input type="radio"/> Not available <input type="radio"/> Previous B positive, current negative <input type="radio"/> Always negative <input type="radio"/> Previous T positive, current negative <input type="radio"/> Current B positive <input type="radio"/> Previous B and T positive, current B and T negative																																																																																																																					
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SECTION 4: TRANSPLANT SURGERY DATA

30. Ischaemic time:	a. Cold <input type="text"/> hours <input type="text"/> minutes	31. Donor kidney:	<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Both
	b. Warm <input type="text"/> hours <input type="text"/> minutes		
32. Artery:	a. Recipient: <input type="checkbox"/> External iliac <input type="checkbox"/> Internal iliac <input type="checkbox"/> Common 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 <input type="text"/> Comment please: _____
33. Vein:	<input type="checkbox"/> External iliac <input type="checkbox"/> Internal iliac <input type="checkbox"/> Common iliac <input type="checkbox"/> Others, specify: _____		
34. Ureter:	<input type="radio"/> Intravesical <input type="radio"/> Extra vesical	35. Stent:	<input type="radio"/> Yes <input type="radio"/> No
36. Surgical Comment:	<input type="text"/>		

SECTION 5: IMMEDIATE POST TRANSPLANT DATA (Please fill this within one month)

37. Graft function	<input type="radio"/> Immediate <input type="radio"/> Delayed <input type="radio"/> Non-function	
38. a. Surgical Complications	b. Urological Complications	c. Management
<input type="checkbox"/> i. Renal artery thrombosis <input type="checkbox"/> v. Others, specify: _____ <input type="checkbox"/> ii. Renal vein thrombosis <input type="checkbox"/> iii. Lymphocele <input type="checkbox"/> iv. Haemorrhage requiring reoperation	<input type="checkbox"/> Urinary tract leak / Urinoma <input type="checkbox"/> Ureteric obstruction / urinary tract stenosis <input type="checkbox"/> Others, specify: _____	<input type="checkbox"/> Conservative / observation <input type="checkbox"/> Surgical intervention, specify: _____ <input type="checkbox"/> Outcome of Management, comments: _____