

# LIVER TRANSPLANT NOTIFICATION FORM

Instruction: Complete this form to notify all transplant patients in your centre to National Transplant Registry.  
Where check boxes are provided, check **one box** as appropriate unless specified otherwise.  
NA refers to Not Applicable. Fill in the date with dd/mm/yy format.

Office use:			
Centre:			

Name of reporting centre: _____	Date of Notification (dd/mm/yy):	
Name of transplant centre: _____	Date of Transplant (dd/mm/yy):	
Place of transplant centre:	<input type="checkbox"/> Local <input type="checkbox"/> China <input type="checkbox"/> India <input type="checkbox"/> Australia <input type="checkbox"/> USA <input type="checkbox"/> Singapore <input type="checkbox"/> UK <input type="checkbox"/> Others, specify: _____	
Date of discharge / death:		
Graft Number:		

## SECTION 1 : RECIPIENT DETAILS

1. Name:				2. RN:	
3. Identification Card Number :	Old IC:			New IC:	
	Other ID document num:			Specify type (eg. passport, armed force ID):	
	<12 years: Birth cert # :		I/C Guardian: Mother / Father	Sibling ranking:	
4. Address:					
	Postcode:	Town/City:	State:		
5. Contact number:	Home: _____	H/P: _____	Work: _____	Ext: _____	
6. Date of Birth (dd/mm/yy):		7. Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	8. a) Weight (kg):	b. Height (cm):
9. Ethnic group:	<input type="checkbox"/> Malay	<input type="checkbox"/> Indian	<input type="checkbox"/> Bumiputra Sabah, specify: _____		
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Bumiputra Sarawak, specify: _____		<input type="checkbox"/> Others, specify: _____	
10. Primary liver disease(s): <i>(check one or more boxes below if present)</i>					
<input type="checkbox"/> Biliary atresia	<input type="checkbox"/> Primary biliary cirrhosis	<input type="checkbox"/> Malignancies, specify: _____			
<input type="checkbox"/> Metabolic liver disease, specify: _____	<input type="checkbox"/> Primary sclerosing cholangitis	<input type="checkbox"/> Acute liver failure, specify cause: _____			
<input type="checkbox"/> Cholestatic liver disease, specify: _____	<input type="checkbox"/> Autoimmune hepatitis	<input type="checkbox"/> Idiopathic/Cryptogenic			
	<input type="checkbox"/> Chronic hepatitis B	<input type="checkbox"/> Others, specify: _____			
	<input type="checkbox"/> Chronic hepatitis C				
	<input type="checkbox"/> Alcoholic liver disease				
11. Indication for transplantation: <i>(check one or more boxes below if present)</i>			12. Current immunosuppressive drug(s) treatment: <i>(check one or more boxes below if present)</i>		
<input type="checkbox"/> a. Recurrent encephalopathy <input type="checkbox"/> b. Uncontrolled bleeding varices <input type="checkbox"/> c. Intractable ascites <input type="checkbox"/> d. Spontaneous bacterial peritonitis <input type="checkbox"/> e. Poor liver function <input type="checkbox"/> f. Malignancy <input type="checkbox"/> g. Unacceptable quality of life <input type="checkbox"/> h. Failure to thrive and growth retardation in paediatric patients <input type="checkbox"/> i. Others, specify: _____			<input type="checkbox"/> a. Steroids <input type="checkbox"/> b. Azathioprine <input type="checkbox"/> c. Cyclosporin A <input type="checkbox"/> d. Tacrolimus (FK506) <input type="checkbox"/> e. Mycophenolate Mofetil (MMF) <input type="checkbox"/> f. Rapamycin <input type="checkbox"/> g. Monoclonal / Polyclonal antibody <input type="checkbox"/> h. Anti IL2R Antibodies <input type="checkbox"/> i. Others, specify: _____		

## SECTION 2 : DONOR DETAILS

13. Age:		14. Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	15. a) Weight (kg):		b. Height (cm):	
16. Ethnic group:	<input type="checkbox"/> Malay	<input type="checkbox"/> Indian	<input type="checkbox"/> Bumiputra Sabah, specify: _____		<input type="checkbox"/> Others, specify: _____		
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Bumiputra Sarawak, specify: _____					
17. Type of donor:							
<input type="checkbox"/> Cadaveric				OR <input type="checkbox"/> Living donor			
<input type="checkbox"/> Brain Death <input type="checkbox"/> Non-heart Beating				<input type="checkbox"/> Related <input type="checkbox"/> Unrelated			
Preop Inotropes: <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Genetically related <input type="checkbox"/> Emotional			
Cause of death: <input type="checkbox"/> Head injury <input type="checkbox"/> CVA <input type="checkbox"/> Others: _____				<input type="checkbox"/> Mother <input type="checkbox"/> Wife <input type="checkbox"/> Father <input type="checkbox"/> Husband <input type="checkbox"/> Daughter <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Son <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Monozygotic twin <input type="checkbox"/> Dizygotic twin <input type="checkbox"/> Other specify: _____			
Date of death (dd/mm/yy):				Date of procurement (dd/mm/yy):			
Time of death (hh:mm):		:   (hours)		Time of procurement (hh:mm):		:   (hours)	
Procurement centre: _____							

### SECTION 3 : RECIPIENT - DONOR MATCH DATA

		Recipient				Donor			
<b>18. ABO Blood Group</b>	<input type="checkbox"/> NA	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> AB	<input type="checkbox"/> O	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> AB	<input type="checkbox"/> O
<b>19. Virology</b> <small>(check one or more boxes below if present)</small>		<u>Positive</u>	<u>Negative</u>	<u>Not Done</u>		<u>Positive</u>	<u>Negative</u>	<u>Not Done</u>	
HIV Screening (Anti HIV I / II)	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CMV IgG	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hep B HBsAg	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti HBs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti HBc (IgG)(total)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HBeAg		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HBV DNA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hep C Anti HCV	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EBV IgG	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RPR VDRL	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### SECTION 4 : TRANSPLANT SURGERY DATA

<b>20. a. Organ grafted</b>	<input type="checkbox"/> Whole <input type="checkbox"/> Reduced <input type="checkbox"/> Split <input type="checkbox"/> Auxiliary	} <b>If Yes</b>	<input type="checkbox"/> Right lobe <input type="checkbox"/> Left lobe <input type="checkbox"/> Left lobe extended
<b>b. Weight of liver graft (g):</b>			
<b>21. Duration of Surgery:</b>	<b>Donor (hh:mm):</b>	:	
	<b>Recipient (hh:mm):</b>	:	

### SECTION 5 : COMPLICATIONS

<b>22. Complications</b> <small>(check one or more boxes below if present)</small>
<input type="checkbox"/> a. Hepatic artery thrombosis
<input type="checkbox"/> b. Portal vein thrombosis
<input type="checkbox"/> c. IVC/hepatic vein occlusion
<input type="checkbox"/> d. Haemorrhage requiring reoperation
<input type="checkbox"/> e. CMV infection
<input type="checkbox"/> f. Fungal infection
g. Post operative sepsis confirmed?
<input type="checkbox"/> i. Sputum
<input type="checkbox"/> ii. Blood
<input type="checkbox"/> iii. Urine
<input type="checkbox"/> iv. Ascites/Drain fluid
<input type="checkbox"/> v. Wound
<input type="checkbox"/> vi. Other
<input type="checkbox"/> h. Biliary tract leaks
<input type="checkbox"/> i. Biliary tract stricture requiring intervention
<input type="checkbox"/> j. Graft rejection
<input type="checkbox"/> k. Others, specify: _____

### SECTION 6 : OUTCOME DATA

<b>23. Outcome</b> <small>(check one or more boxes below if present)</small>	<b>Date (dd/mm/yy):</b>
a. <input type="checkbox"/> <b>Alive with functioning graft / tissue</b>	
b. <input type="checkbox"/> <b>Retransplant, specify cause:</b> _____	
c. <input type="checkbox"/> <b>Graft failure, specify cause:</b> _____	
d. <input type="checkbox"/> <b>Transplant-related death, specify cause:</b> _____	
e. <input type="checkbox"/> <b>Intraoperative death, specify cause:</b> _____	
f. <input type="checkbox"/> <b>Death due to other causes, specify cause:</b> _____	
g. <input type="checkbox"/> <b>Moved to another centre, name of new centre:</b> _____	
h. <input type="checkbox"/> <b>Lost to follow-up</b>	