

# CORNEA TRANSPLANT OUTCOME FORM

Instruction: Complete this form at 12th month and annually after cornea transplant surgery. Where check boxes are provided, check one box as appropriate unless otherwise specified.

Indicate the events occurring since last reporting. Please return completed form to the NTR at the following address:

**National Transplant Registry**  
 2nd Floor, MMA House,  
 124 Jalan Pahang,  
 53000 Kuala Lumpur.

Office use:  /  /   
 Centre:

Name of reporting centre: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date (dd/mm/yy):

I/C No: \_\_\_\_\_

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<b>1. Duration after surgery:</b>	<input type="checkbox"/> 12 months	<input type="checkbox"/> _____ Years
<b>2. Operated Eye:</b>	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<b>3. Date of transplant (dd/mm/yy):</b>	<input type="text"/>	<input type="text"/>
<b>4. Patient current status:</b>	<input type="checkbox"/> Alive	
	<input type="checkbox"/> Lost to follow-up	<b>Date of last follow-up (dd/mm/yy):</b> <input type="text"/>
	<input type="checkbox"/> Transfer to a new centre	<b>Date of transfer (dd/mm/yy):</b> <input type="text"/> <b>Name of new centre:</b> _____
	<input type="checkbox"/> Dead	<b>Date of death (dd/mm/yy):</b> <input type="text"/>

## POST TRANSPLANT DATA

<b>5. Current topical steroids:</b>	<input type="checkbox"/> Yes → <b>Frequency:</b> <input type="text"/> / day
	<input type="checkbox"/> No
<b>6. Current systemic immunosuppression:</b>	<input type="checkbox"/> Yes, specify: _____
	<input type="checkbox"/> No
<b>7. Graft Clear:</b>	<input type="checkbox"/> Yes <span style="float: right;"><input type="checkbox"/> No</span>
<b>8. Graft Failure?</b>	<input type="checkbox"/> Yes <span style="float: right;"><input type="checkbox"/> No</span>
↓	
<b>a. Date of failure (dd/mm/yy):</b> <input type="text"/>	<b>c. Specify cause of loss of graft clarity:</b>
<b>b. Cause of Failure:</b> <i>(check one or more boxes if present)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Primary graft failure</li> <li><input type="checkbox"/> Recurrence of primary disease</li> <li><input type="checkbox"/> Primary Endothelial decompensation</li> <li><input type="checkbox"/> Late Endothelial decompensation</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Infection</li> <li><input type="checkbox"/> Graft rejection</li> <li><input type="checkbox"/> Others, specify: _____</li> </ul>	

<b>9. Graft Rejection</b>	<input type="checkbox"/> Yes <span style="float: right;"><input type="checkbox"/> No</span>
↓	
<input type="checkbox"/> Epithelial <span style="margin-left: 100px;"><input type="checkbox"/> Stromal</span> <span style="float: right;"><input type="checkbox"/> Endothelial</span>	
↓	

Rejection	Date (dd/mm/yy)	Outcome	Treatment Modality <small>(check one or more boxes below if present)</small>
Episode 1	<input type="text"/>	<input type="checkbox"/> Clear <input type="checkbox"/> Not clear	<input type="checkbox"/> topical steroid <input type="checkbox"/> IV methylprednisolone <input type="checkbox"/> oral prednisolone <input type="checkbox"/> oral cyclosporine <input type="checkbox"/> others, specify: _____
Episode 2	<input type="text"/>	<input type="checkbox"/> Clear <input type="checkbox"/> Not clear	<input type="checkbox"/> topical steroid <input type="checkbox"/> IV methylprednisolone <input type="checkbox"/> oral prednisolone <input type="checkbox"/> oral cyclosporine <input type="checkbox"/> others, specify: _____
Episode 3	<input type="text"/>	<input type="checkbox"/> Clear <input type="checkbox"/> Not clear	<input type="checkbox"/> topical steroid <input type="checkbox"/> IV methylprednisolone <input type="checkbox"/> oral prednisolone <input type="checkbox"/> oral cyclosporine <input type="checkbox"/> others, specify: _____

**10. Other Complications** (check one or more boxes below if present)  NIL

	Date (dd/mm/yy)
a. <input type="checkbox"/> Epithelial Problem	
b. <input type="checkbox"/> Wound Dehiscence	
c. <input type="checkbox"/> Suture infiltration / abscess	
d. <input type="checkbox"/> Endophthalmitis	
e. <input type="checkbox"/> Microbial keratitis	
f. <input type="checkbox"/> Vascularization	
g. <input type="checkbox"/> Post-keratoplasty glaucoma	

**11. Vision:**

Date (dd/mm/yy)	Unaided VA	Pinhole VA	Best Corrected VA	Refraction*	Means of Refractive Error Correction
				a) SPH: <input type="text"/> b) CYL: <input type="text"/> c) AXIS: <input type="text"/>	<input type="checkbox"/> Spectacle <input type="checkbox"/> Contact Lens

\* If refraction not performed, leave box blank.  
a) SPH - Spherical  
b) CYL - Cylinder

**12. Post-op Procedure:**  
(check one or more boxes if present)

<input type="checkbox"/> NIL		
<input type="checkbox"/> Refractive Surgery	→	Type: <input type="text"/> Date (dd/mm/yy): <input type="text"/>
<input type="checkbox"/> Cataract Surgery	→	<input type="text"/>
<input type="checkbox"/> Glaucoma Surgery	→	<input type="text"/>
<input type="checkbox"/> Retinal Surgery	→	<input type="text"/>
<input type="checkbox"/> Others	→	<input type="text"/>

**13. Graft Suture:**

<input type="checkbox"/> Not removed	
<input type="checkbox"/> First planned removal	→ Date (dd/mm/yy): <input type="text"/>
<input type="checkbox"/> All removed	→ Date (dd/mm/yy): <input type="text"/>

**14. Factor for Post-op vision BCVA worse than 6/12:** (check one or more boxes below if present)

- NIL
- High astigmatism
- Glaucoma
- Retinal Detachment
- Cataract
- Cornea Decompensation
- DM Retinopathy
- Others, specify: \_\_\_\_\_

**Form Completed By:** \_\_\_\_\_  
(Name and Official Stamp)

**Signature:** \_\_\_\_\_