

CORNEA TRANSPLANT NOTIFICATION FORM

*Instruction: Complete this Cornea transplant data form for all patients who have undergone transplantation from year 2004. 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.*

Please fill in one form per cornea transplant. Please return the form to NTR within one month post transplantation.

Office use:			
Centre:			

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

Name of reporting centre: _____	Date of Notification:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">dd</td> <td style="width: 33%; text-align: center;">mm</td> <td style="width: 33%; text-align: center;">yy</td> </tr> </table>	dd	mm	yy
dd	mm	yy			
Name of transplant centre: _____	Date of Transplant:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">dd</td> <td style="width: 33%; text-align: center;">mm</td> <td style="width: 33%; text-align: center;">yy</td> </tr> </table>	dd	mm	yy
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: _____				

SECTION 1 : RECIPIENT DETAILS

1. Name: _____	2. RN: _____
3. Identification Card Number :	<i>Old IC:</i> _____ <i>New IC:</i> _____
	<i>Other ID document num:</i> _____ <i>Specify type (eg. passport, armed force ID):</i> _____
	<i><12 years: Birth cert # :</i> _____ <i>I/C Guardian: Mother / Father</i>
4. Address:	Postcode: _____ Town/City: _____ State: _____
5. Contact number:	Homephone: _____ Handphone: _____ Workphone: _____ Ext: _____
6. Date of Birth (dd/mm/yy): _____	7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
8. 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: _____
9. Nationality:	<input type="checkbox"/> Malaysian <input type="checkbox"/> Non-Malaysian, specify: _____

SECTION 2: PRE TRANSPLANT DATA

10. Diagnosis: <i>(check one or more boxes if present)</i>	<input type="checkbox"/> Pseudophakic Bullous keratopathy <input type="checkbox"/> Other bullous keratopathy, specify cause: _____ <input type="checkbox"/> Keratoconus <input type="checkbox"/> Failed previous graft <input type="checkbox"/> Corneal dystrophy, specify: _____ <input type="checkbox"/> Congenital opacity <input type="checkbox"/> Corneal perforation <input type="checkbox"/> Microbial keratitis <input type="checkbox"/> Corneal scar, specify cause: _____ <input type="checkbox"/> Others, specify: _____			
11. Operated Eye:	<input type="checkbox"/> Right <input type="checkbox"/> Left			
12. Indication of transplant: <i>(check one or more boxes if present)</i>	<input type="checkbox"/> Optical <input type="checkbox"/> Therapeutic <input type="checkbox"/> Tectonic <input type="checkbox"/> Others, specify: _____			
13. No of previous grafts in grafted eye:	<input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> Others, specify: _____			
14. Ocular co-morbidity				
a. Cornea vascularization:	<input type="checkbox"/> No vascularization <input type="checkbox"/> Superficial vascularization <input type="checkbox"/> Deep vascularization - If Yes → quadrant: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> </table>	Yes	No	
Yes	No			
b. History of glaucoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
c. Current ocular inflammation:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
d. Others, specify:	_____			
15. Pre-op Visual data				
Unaided VA	Pinhole VA	Best Corrected VA	Refraction*	Means of Refractive Error Correction
			a) SPH: _____ b) CYL: _____ c) AXIS: _____	<input type="checkbox"/> Spectacle <input type="checkbox"/> Contact Lens

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

SECTION 3 : DONOR DETAILS

16. Eye Bank No / IC No:																																	
17. Source of Donor:	<input type="checkbox"/> Local - If Yes → Ethnic group: <input type="checkbox"/> Malay <input type="checkbox"/> Bumiputra Sarawak, specify: _____ <input type="checkbox"/> USA <input type="checkbox"/> Chinese <input type="checkbox"/> Bumiputra Sabah, specify: _____ <input type="checkbox"/> Sri Lanka <input type="checkbox"/> Indian <input type="checkbox"/> Others, specify: _____ <input type="checkbox"/> Others, specify: _____																																
18. Preservation Media:	<input type="checkbox"/> Optisol GS <input type="checkbox"/> MK Medium <input type="checkbox"/> Moist Chamber <input type="checkbox"/> Others, specify: _____																																
19. Age:																																	
20. Cause of death: <i>(check one or more boxes if present)</i>	<input type="checkbox"/> Cardiac / Circulatory System <input type="checkbox"/> Cerebrovascular System <input type="checkbox"/> Malignancies, specify: _____ <input type="checkbox"/> Trauma / Accident <input type="checkbox"/> Respiratory System <input type="checkbox"/> Others, specify: _____																																
21. a. Date of death (dd/mm/yy):	21. b. Time of death (hh:mm): _____ : _____ (hours)																																
22. a. Date of procurement (dd/mm/yy):	22. b. Time of procurement (hh:mm): _____ : _____ (hours)																																
23. a. Date of preservation (dd/mm/yy):	23. b. Time of preservation (hh:mm): _____ : _____ (hours)																																
24. Procurement centre:																																	
25. Endothelial Cell Count (mm ²):	<input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> NA																																
26. Serology	<table border="1"> <thead> <tr> <th></th> <th></th> <th>Positive</th> <th>Negative</th> </tr> </thead> <tbody> <tr> <td>HIV Screening (Anti HIV I / II)</td> <td><input type="checkbox"/> NA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep B HBsAg</td> <td><input type="checkbox"/> NA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Anti HBs</td> <td><input type="checkbox"/> NA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Anti HBc (IgG)(total)</td> <td><input type="checkbox"/> NA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HBeAg</td> <td><input type="checkbox"/> NA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep C Anti HCV</td> <td><input type="checkbox"/> NA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>RPR-VDRL</td> <td><input type="checkbox"/> NA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>			Positive	Negative	HIV Screening (Anti HIV I / II)	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	Hep B HBsAg	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	Anti HBs	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	Anti HBc (IgG)(total)	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	HBeAg	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	Hep C Anti HCV	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	RPR-VDRL	<input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>
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SECTION 4: TRANSPLANT SURGERY DATA

27. Name of Surgeon:	
28. Type of surgery:	<input type="checkbox"/> Penetrating Keratoplasty <input type="checkbox"/> Patch Graft For Scleral <input type="checkbox"/> Lamellar Keratoplasty <input type="checkbox"/> Cornea Scleral Lamellar Keratopalsty <input type="checkbox"/> Patch Graft For Corneal <input type="checkbox"/> Others, specify: _____
29. Combined Surgery:	<input type="checkbox"/> Yes If Yes → <i>(check one or more boxes below if present)</i> <input type="checkbox"/> Glaucoma — If Yes → <input type="checkbox"/> Trabeculectomy <input type="checkbox"/> Setons <input type="checkbox"/> Cataract Extraction — If Yes → <input type="checkbox"/> ECCE <input type="checkbox"/> ICCE <input type="checkbox"/> Phaco <input type="checkbox"/> IOL — If Yes → <input type="checkbox"/> AC Lens <input type="checkbox"/> PC Lens <input type="checkbox"/> Scleral fixated <input type="checkbox"/> Iris fixated <input type="checkbox"/> Retinal Surgery +/- Internal Temponade <input type="checkbox"/> Anterior vitrectomy <input type="checkbox"/> Others, specify: _____ <input type="checkbox"/> No
30. Graft Size:	a. Recipient: _____ mm <input type="checkbox"/> Freehand b. Donor: _____ mm <input type="checkbox"/> Freehand
31. Type of trephine used (recipient):	<input type="checkbox"/> Manual <input type="checkbox"/> Mechanical
32. Suture Technique:	<input type="checkbox"/> Interrupted <input type="checkbox"/> Continuous <input type="checkbox"/> Combined
33. Intraoperative Complication:	<input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> No

Form Completed By: _____ (Name and Official Stamp)

Signature: _____