RENAL TRANSPLANT ANNUAL RETURN FORM

Office use: / Centre:

Instruction: Complete this annual return form and return by 31st December to the National Transplant Registry. Where check boxes are provided, check one box as appropriate unless otherwise specified.

Name of reporting centre: _____

Patient Name: _____

I/C No.: (Old) (New) _____

The NTR Address:
National Transplant Registry
c/o Clinical Registry Unit
2nd Floor, 29 & 31 Jalan Ipoh,
51200 Kuala Lumpur

Date: dd mm yy

SECTION 1 : OUTCOME DATA

1. Patient outcome data — **Date (dd/mm/yy):**

- a. ☐ **Alive with functioning graft / tissue**
- b. ☐ **Acute rejection**
- c. ☐ **Graft failure**
- d. ☐ **Death**
- e. ☐ **Moved to another centre**
- f. ☐ **Lost to follow-up**

Mode of RRT: ☐ HD ☐ CAPD ☐ Retransplant

Name of new centre: _____

SECTION 2 : BIOCHEMICAL

(Most recent result) **Date (dd/mm/yy):**

2.

Biochemical parameters	Unit	Value	Biochemical parameters	Unit	Value
a. Creatinine	µmol/L		**f. Alkaline Phosphate (ALP)**	U/L	
b. Hb	g/dL		**g. ALT**	U/L	
c. Albumin	g/L		**h. Total cholesterol**	mmol/L	
d. Calcium	mmol/L		**i. LDL Cholesterol**	mmol/L	
e. Phosphate	mmol/L		**j. HDL Cholesterol**	mmol/L	

SECTION 3 : VITAL SIGNS

Date (dd/mm/yy):

3.

a. Weight	kg	
b. B.P.	mmHg	

SECTION 4 : MEDICATION

Date (dd/mm/yy):

(check one or more boxes below if present)

4. Immunosuppressive drug(s) treatment:

- ☐ a. Prednisolone
- ☐ b. Azathioprine
- ☐ c. Cyclosporin A
- ☐ d. Tacrolimus (FK506)
- ☐ e. Mycophenolate Mofetil (MMF)
- ☐ f. Rapamycin
- ☐ g. Others, specify: _____

5. Non-Immunosuppressive drug(s) treatment:

- ☐ a. Beta blocker
- ☐ b. Calcium channel blocker
- ☐ c. ACE inhibitor
- ☐ d. AIIRB
- ☐ e. Anti-lipid
- ☐ f. Other anti-hypertensive, specify: _____

SECTION 5 : POST TRANSPLANT COMPLICATIONS

6. Diabetes: ☐ Yes — **If Yes** → a. Date (dd/mm/yy): ☐ No

7. Cancer: ☐ Yes — **If Yes** → a. Specify: _____ Date (dd/mm/yy): ☐ No

8. Cardiovascular disease: ☐ Yes — **If Yes** → a. ☐ Coronary ☐ Non coronary ☐ CVA — Date (dd/mm/yy): ☐ No

9. Decompensated liver disease: ☐ Yes — **If Yes** → a. ☐ Hep B ☐ Drug, specify: _____ ☐ Hep C ☐ Others, specify: _____ — Date (dd/mm/yy): ☐ No

10. Infection *(check one or more boxes if present)*

	Date (dd/mm/yy):
☐ i. CMV infection, specify site(s): _____	
☐ ii. PCP	
☐ iii. Hepatitis B	
☐ iv. Hepatitis C	
☐ v. Others, specify: _____	

11. Surgical:

- ☐ Renal artery stenosis — **If Yes** → a. Date (dd/mm/yy):
- ☐ Obstructive uropathy, specify: _____ — **If Yes** → a. Date (dd/mm/yy):