CORNEA TRANSPLANT NOTIFICATION FORM

Instruction: Complete this Cornea transplant data form for all patients who have undergone transplantation Where check boxes ☐ are provided, check (√) one or more boxes. Where radio buttons ◉ are provided, check (√) one box only. NA refers to Not Applicable. Fill in the date with dd/mm/yyyy format. Please fill in one form per cornea transplant. Please return the form to NTR within one month post tranplantation.

Address:

National Transplant Registry
Level 5, Menara Wisma Sejarah
230, Jalan Tun Razak
50400 Kuala Lumpur

Office use: ____ / ____
Centre: ____

i. Name of reporting centre: *		**ii. Date of Notification :** (dd/mm/yyyy)	__ __ / __ __ / __ __ __ __
iii. Name of transplant centre: *		**iv. Date of Transplant :** * (dd/mm/yyyy)	__ __ / __ __ / __ __ __ __
iv. Place of transplant centre:	◉ Local ◉ China ◉ India ◉ Australia ◉ USA ◉ Singapore ◉ UK ◉ Others, specify: _____		

SECTION 1 : RECIPIENT DETAILS

1. Name : * *(Please print in capital letters)*

2. R/N No.:

3. NRIC : *

MyKad: __ __ __ __ __ __ - __ __ - __ __ __ __ Old IC: __ __ __ __ __ __ __ __

Other ID document No:

Specify document type (if others): ◉ Registration number ◉ Mother's I/C ◉ Armed Force ID ◉ Date of Birth ◉ Passport ◉ Father's I/C ◉ Work Permit # ◉ Lab number ◉ Others

<12 years: Birth cert # : *I/C Guardian:* Mother / Father Sibling ranking: __

4. Address:

Postcode: __ __ __ __ __ Town / City:

State : ◉ Johor Darul Takzim ◉ Kedah Darul Aman ◉ Kelantan Darul Naim ◉ Melaka ◉ Negeri Sembilan Darul Khusus ◉ Pahang Darul Makmur ◉ Perak Darul Ridzuan ◉ Perlis Indera Kayangan ◉ Pulau Pinang ◉ Sabah ◉ Sarawak ◉ Selangor Darul Ehsan ◉ Terengganu Darul Iman ◉ Wilayah Persekutuan Kuala Lumpur ◉ Wilayah Persekutuan Labuan, Sabah ◉ Wilayah Persekutuan Putrajaya ◉ Not applicable - Foreign

5. Contact number: a. Home: b. Handphone: c. Work: d. Ext:

6a. Date of Birth: * (dd/mm/yyyy) __ __ / __ __ / __ __ __ __ (autofill if MyKad is available)
If the exact date is not known, please enter 01/07/yyyy

6b. Age: (autocalculate) __ __ . __ __

7. Gender: ◉ Male ◉ Female

8. Ethnic group: * ◉ Malay ◉ Indian ◉ Bumiputra Sarawak, specify: ◉ Chinese ◉ Bumiputra Sabah, specify: ◉ Others, specify:

9. Nationality: ◉ Malaysian ◉ Non-Malaysian, specify:

SECTION 2: PRE TRANSPLANT DATA

1. Diagnosis: *

☐ Pseudophakic Bullous keratopathy
☐ Other bullous keratopathy, specify cause: _____
☐ Keratoconus
☐ Failed previous graft
☐ Corneal dystrophy, specify: _____
☐ Congenital opacity
☐ Corneal perforation
☐ Microbial keratitis
☐ Corneal scar, specify cause: _____
☐ Others, specify: _____

2. Operated Eye: * ◉ Right ◉ Left

3. Indication of transplant: ☐ Optical ☐ Therapeutic ☐ Tectonic ☐ Others, specify: _____

4. No of previous grafts in grafted eye: ◉ 0 ◉ 2 ◉ 1 ◉ Others, specify: _____

5. Ocular co-morbidity

a. Cornea vascularization: ☐ No vascularization ☐ Superficial vascularization ☐ Deep vascularization – **If Yes** → quadrant: ◉ 1 ◉ 2 ◉ 3 ◉ 4

b. History of glaucoma: ◉ Yes ◉ No

c. Current ocular inflammation: ◉ Yes ◉ No

d. Others, specify

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SECTION 2: PRE TRANSPLANT DATA (cont'd)

6. Pre-op Visual data

* a) Unaided VA	b) Best Corrected VA	c) Improved with refraction
◉ 6/6 ◉ 6/9 ◉ 6/12 ◉ 6/18 ◉ 6/24 ◉ 6/36 ◉ 6/60 ◉ 5/60 ◉ 4/60 ◉ 3/60 ◉ 2/60 ◉ 1/60 ◉ CF ◉ HM ◉ PL ◉ NPL ◉ NIPH ◉ Others, specify: ____	◉ 6/6 ◉ 6/9 ◉ 6/12 ◉ 6/18 ◉ 6/24 ◉ 6/36 ◉ 6/60 ◉ 5/60 ◉ 4/60 ◉ 3/60 ◉ 2/60 ◉ 1/60 ◉ CF ◉ HM ◉ PL ◉ NPL ◉ NIPH ◉ Others, specify: ____	◉ Yes → Refraction**: a) SPH: ____ b) CYL: ____ c) AXIS: ____ ◉ No

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

SECTION 3 : DONOR DETAILS

1. Eye Bank No / IC No:

2. Source of Donor:
◉ Local – **If Yes** → **Ethnic group:** ◉ Malay ◉ Chinese ◉ Indian ◉ Bumiputra Sarawak, specify: ____ ◉ Bumiputra Sabah, specify: ____ ◉ Others, specify: ____
◉ USA
◉ Sri Lanka
◉ Others, specify: ____

3. Preservation Media: ◉ Optisol GS ◉ MK Medium ◉ Moist Chamber ◉ Others, specify: ____

4. Age: ☐☐

5. Cause of death:
☐ Cardiac / Circulatory System
☐ Cerebrovascular System
☐ Malignancies, specify: ____
☐ Trauma / Accident
☐ Respiratory System
☐ Others, specify: ____
☐ Unknown

6. a. Date of death (dd/mm/yyyy): ☐☐ / ☐☐ / ☐☐☐☐ **6. b. Time of death (hh:mm):** ☐☐ : ☐☐ (24 hrs clock)

7. Procurement centre:

8. Endothelial Cell Count (mm ²): ◉ Yes, specify: ____ ◉ NA

SECTION 4: TRANSPLANT SURGERY DATA

1. Name of Surgeon: *

2. Type of surgery: *
◉ Penetrating Keratoplasty
◉ Deep Anterior Lamellar Keratoplasty
◉ Other Anterior Lamellar Keratoplasty
◉ Posterior Lamellar Keratoplasty
◉ Cornea Scleral Lamellar Keratoplasty
◉ Others, specify: ____

3. Combined Surgery:
◉ Yes — **If Yes** →
- ☐ Glaucoma — **If Yes** → ◉ Trabeculectomy ◉ Setons
- ☐ Cataract Extraction — **If Yes** → ◉ ECCE ◉ ICCE ◉ Phaco
- ☐ IOL — **If Yes** → ☐ AC Lens ☐ PC Lens ☐ Scleral fixated ☐ Iris fixated
- ☐ Retinal Surgery +/- Internal Temponade
- ☐ Anterior vitrectomy
- ☐ Limbal Stem Cell Transplantation
- ☐ Others, specify: ____

◉ No

4. Graft Size: **a. Recipient:** (mm) ☐☐.☐☐ ☐ Freehand **b. Donor:** (mm) ☐☐.☐☐ ☐ Freehand

5.Type of trephine used (recipient): ◉ Manual ◉ Mechanical

6. Suture Technique: ☐ Interrupted ☐ Continuous ☐ Combined ☐ Sutureless

7. Intraoperative Complication: ◉ Yes, specify: ____ ◉ No

Form Completed By: ____
(Name and Official Stamp)

Signature: ____