

NATIONAL TRANSPLANT REGISTRY (NTR) LIVER TRANSPLANT NOTIFICATION FORM

For Office Use only:

ID: /

Centre:

Instruction: Complete this form to notify all transplant patients in your centre to National Transplant Registry. 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/yy format.

i. Name of reporting centre: *	ii. Date of Notification : (dd/mm/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
iii. Name of transplant centre: *	iv. Date of Transplant : * (dd/mm/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
v. Place of transplant centre:	<input type="radio"/> Local <input type="radio"/> China <input type="radio"/> India <input type="radio"/> Australia <input type="radio"/> USA <input type="radio"/> Singapore <input type="radio"/> UK <input type="radio"/> Others, specify: _____
vi. Date:	<input type="radio"/> Date of discharge <input type="radio"/> Date of death → <input type="text"/> / <input type="text"/> / <input type="text"/>
vii. Graft Number: <input type="text"/>	

SECTION 1 : RECIPIENT DETAILS

1. Name : * (Please print in capital letters)	<input style="width: 100%;" type="text"/>		
2. R/N No.:	<input style="width: 100%;" type="text"/>		
3. NRIC : *	MyKad: <input type="text"/> - <input type="text"/> - <input type="text"/> Old IC: <input type="text"/>		
	Other ID document No: <input style="width: 100%;" type="text"/>		
	Specify document type (if others):	<input type="radio"/> Registration number <input type="radio"/> Mother's I/C <input type="radio"/> Armed Force ID <input type="radio"/> Date of Birth <input type="radio"/> Passport <input type="radio"/> Father's I/C <input type="radio"/> Work Permit # <input type="radio"/> Lab number <input type="radio"/> Others	
	<12 years: Birth cert # : <input type="text"/> I/C Guardian: Mother / Father <input type="text"/>	Sibling ranking: <input type="text"/>	
4. Address:	Postcode: <input type="text"/> Town / City: <input style="width: 100%;" type="text"/>		
	State : <input type="radio"/> Johor Darul Takzim <input type="radio"/> Pahang Darul Makmur <input type="radio"/> Sarawak <input type="radio"/> Wilayah Persekutuan Labuan, Sabah <input type="radio"/> Kedah Darul Aman <input type="radio"/> Perak Darul Ridzuan <input type="radio"/> Selangor Darul Ehsan <input type="radio"/> Wilayah Persekutuan Putrajaya <input type="radio"/> Kelantan Darul Naim <input type="radio"/> Perlis Indera Kayangan <input type="radio"/> Terengganu Darul Iman <input type="radio"/> Wilayah Persekutuan Kuala Lumpur <input type="radio"/> Melaka <input type="radio"/> Pulau Pinang <input type="radio"/> <input type="radio"/> Not applicable - Foreign <input type="radio"/> Negeri Sembilan Darul Khusus <input type="radio"/> Sabah		
	Home <input type="text"/> Handphone: <input type="text"/> Work: <input type="text"/> Ext: <input type="text"/>		
5. Contact number:			
6. Date of Birth: * (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="checkbox"/> Estimated / presumed year (autofill if MyKad is available)	7. Age: (autocalculate) <input type="text"/>	8. Gender: * <input type="radio"/> Male <input type="radio"/> Female
<small>If the exact date is not known, please enter 01/07/yyyy & check the estimated/presumed year box</small>			
9. a) Weight: (kg)	9. b) Height (cm)		
10. Ethnic group: *	<input type="radio"/> Malay <input type="radio"/> Indian <input type="radio"/> Bumiputra Sarawak, specify: _____ <input type="radio"/> Chinese <input type="radio"/> Bumiputra Sabah, specify: _____ <input type="radio"/> Others, specify: _____		
11. Primary liver disease(s): *	<input type="checkbox"/> Biliary atresia a. Kasai? <input type="radio"/> Yes <input type="radio"/> No ↓ Date of kasai operation: <input type="text"/> : <input type="text"/> (24 hours)		
	<input type="checkbox"/> Malignancies, specify: _____ <input type="radio"/> Hepatocellularcarcinoma <input type="radio"/> Other, specify _____		
	<input type="checkbox"/> Primary sclerosing cholangitis <input type="checkbox"/> Acute liver failure, specify cause: _____ <input type="checkbox"/> Acute on chronic liver failure <input type="checkbox"/> Idiopathic/Cryptogenic <input type="checkbox"/> Others, specify: _____ <input type="checkbox"/> Unknown		
12. Indication for * transplantation:	<input type="checkbox"/> a. Recurrent encephalopathy <input type="checkbox"/> f. Malignancy <input type="checkbox"/> Unknown <input type="checkbox"/> b. Uncontrolled bleeding varices <input type="checkbox"/> g. Unacceptable quality of life <input type="checkbox"/> c. Intractable ascites <input type="checkbox"/> h. Failure to thrive and growth retardation in paediatric patients <input type="checkbox"/> d. Spontaneous bacterial peritonitis <input type="checkbox"/> i. Non clearing jaundice <input type="checkbox"/> e. Poor liver function <input type="checkbox"/> j. Others, specify: _____		
13. Current Immuno - suppressive drug(s) treatment: *	<input type="checkbox"/> a. Steroids <input type="checkbox"/> d. Everolimus <input type="checkbox"/> i. Others, specify: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> b. Cyclosporin A <input type="checkbox"/> e. Mycophenolate Mofetil (MMF) <input type="checkbox"/> c. Tacrolimus (FK506) <input type="checkbox"/> f. Mycophenolate sodium (MMS)		
	<input type="radio"/> Advograf <input type="radio"/> Prograf		

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SECTION 2 : DONOR DETAILS

1. Age:	<input type="text"/>	2. Gender:	<input type="radio"/> Male <input type="radio"/> Female	3. a) Weight: (kg)		3. b) Height: (cm)			
4. Ethnic group:	<input type="radio"/> Malay <input type="radio"/> Indian <input type="radio"/> Chinese <input type="radio"/> Bumiputra Sabah, specify: _____		<input type="radio"/> Bumiputra Sarawak, specify: _____ <input type="radio"/> Others, specify: _____						
5. Type of donor:	* <input type="radio"/> Cadaveric ↓ <input type="radio"/> Brain Death <input type="radio"/> Non-heart Beating ↓ Preop Inotropes: <input type="radio"/> Yes <input type="radio"/> No			OR <input type="radio"/> Living donor ↓ <input type="radio"/> Related <input type="radio"/> Unrelated ↓ <input type="radio"/> Genetically related <input type="radio"/> Emotional ↓ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Daughter <input type="radio"/> Son <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Monozygotic twin <input type="radio"/> Dizygotic twin <input type="radio"/> Other specify: _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Wife <input type="radio"/> Husband <input type="radio"/> Other, specify: <input style="width: 100%; height: 40px;" type="text"/> </td> </tr> </table>				<input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Daughter <input type="radio"/> Son <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Monozygotic twin <input type="radio"/> Dizygotic twin <input type="radio"/> Other specify: _____	<input type="radio"/> Wife <input type="radio"/> Husband <input type="radio"/> Other, specify: <input style="width: 100%; height: 40px;" type="text"/>
<input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Daughter <input type="radio"/> Son <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Monozygotic twin <input type="radio"/> Dizygotic twin <input type="radio"/> Other specify: _____	<input type="radio"/> Wife <input type="radio"/> Husband <input type="radio"/> Other, specify: <input style="width: 100%; height: 40px;" type="text"/>								
i. Cause of death:			<input type="radio"/> Head injury <input type="radio"/> CVA <input type="radio"/> Others: _____						
ii. Date of death: (dd/mm/yyyy)			<input type="text"/>						
iii. Time of death:			<input type="text"/> : <input type="text"/> (24 hours)						
iv. Date of procurement			<input type="text"/>						
v. Time of procurement			<input type="text"/> : <input type="text"/> (24 hours)						
vi. Procurement centre:									
			iv. Date of procurement		<input type="text"/>				
			v. Time of procurement		<input type="text"/> : <input type="text"/> (24 hours)				
			vi. Procurement centre:						

SECTION 3 : RECIPIENT - DONOR MATCH DATA

	Recipient				Donor					
	<input type="radio"/> A	<input type="radio"/> B	<input type="radio"/> AB	<input type="radio"/> O	<input type="radio"/> NA	<input type="radio"/> A	<input type="radio"/> B	<input type="radio"/> AB	<input type="radio"/> O	<input type="radio"/> NA
1. ABO Blood Group										
2. Virology	Positive	Negative	Not Done	NA	Positive	Negative	Not Done	NA		
HIV Screening (Anti HIV I / II)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
CMV IgG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Hep B	HBsAg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Anti HBs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Anti HBc (IgG)(total)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	HBeAg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	HBV DNA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Hep C Anti HCV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
EBV IgG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
RPR-VDRL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

SECTION 4 : TRANSPLANT SURGERY DATA

1 a) Organ grafted	<input type="radio"/> Whole <input checked="" type="radio"/> Reduced <input type="radio"/> Split <input type="radio"/> Auxiliary → <input type="radio"/> Right lobe <input type="radio"/> Left lobe <input type="radio"/> Left lobe extended	
1 b) Weight of liver graft (g):		
2. Duration of Surgery:	i. Donor Time start of surgery: <input type="text"/> : <input type="text"/> (24 hours) Time end of surgery: <input type="text"/> : <input type="text"/> (24 hours)	Duration: <input type="text"/> : <input type="text"/> Auto calc. ii. Recipient (24 hrs) <input type="text"/> : <input type="text"/> (24 hours)

SECTION 5 : COMPLICATIONS

1. Complications:	<input type="checkbox"/> None <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"/> iv. Ascites/Drain fluid <input type="checkbox"/> ii. Blood <input type="checkbox"/> v. Wound <input type="checkbox"/> iii. Urine <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: _____	
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SECTION 6 : OUTCOME DATA

1. Date	<input type="text"/> / <input type="text"/> / <input type="text"/> (Date of outcome / date of death / date of last follow up)		ADD
2. Outcome:	<input type="radio"/> Alive with functioning graft / tissue <input type="radio"/> Moved to another centre, name of new centre: _____ <input type="radio"/> Lost to follow-up		<input type="radio"/> Retransplant <input type="radio"/> Intraoperative death <input type="radio"/> Graft failure <input type="radio"/> Death due to other causes → Specify cause: <input type="radio"/> Transplant-related death