MRRB FOLLOW UP STUDY (NATIVE KIDNEY BIOPSY)

Instruction: Where check boxes ☐ are provided, check (√) one or more boxes. Where radio buttons ◉ are provided, check (√) one box only.

Centre Name: _____

Office use: ____ / ____
Centre: ____

PATIENT PARTICULARS

Name : _____ **RN :** _____

Identification Card Number :

MyKad / MyKid: ____ - ____ - ____ *Old IC:* ____

Other document No: ____ *Specify type (eg.passport, armed force ID):* ____

* **Date of Notification(dd/mm/yyyy):** ____ * **Data Year:** ____

1. Date of last encounter: *			
2. Date of biopsy:	**a. Date 1st Biopsy::** *		
	b.Date 2nd Biopsy:		
	c. Date 3rd Biopsy:		
3. Demographics:	**a. Weight:**	(for paeds)	
	b. Height:	(for paeds)	

4. Laboratory results: *

4a. Urine: *	**a. Urine RBC:**	◉ Yes → ◉ No ◉ Not available	**i.** Urine dipstick ◉ 1+ ◉ 2+ ◉ 3+ **ii.** Urine microscopy ◉ 20-50 cells/ul ◉ >50 cells/ul
	b.Urine Protein:	◉ Yes ◉ No ◉ Not available →	**i. Scale :** ◉ 1+ ◉ 2+ ◉ 3+ ◉ 4+
	c. 24 hrs Urine Protein, (g/day)		☐ Not available
	d. Urine PCI/PCR	____ ◉ mg/mg ◉ mg/g ◉ mg/mmol ◉ g/mmol Autocalc g/mmol	☐ Not available
	e. Urine ACR	____ ◉ mg/mg ◉ mg/g ◉ mg/mmol ◉ g/mmol Autocalc g/mmol	☐ Not available

5. Biochemistry: *				Date
a. Albumin	____ ◉ g/L ◉ g/dL Autocalc g/dL		☐ Not available	__ __ / __ __ / __ __
b. Creatinine *(If on dialysis give pre dialysis result)* *	____ ◉ umol/L ◉ mg/dL Autocalc mg/dL		☐ Not available	__ __ / __ __ / __ __
c. Others				__ __ / __ __ / __ __
d. eGFR	Autocalc			
e. CKD Grade	Autocalc			

6. Medications or * treatments prescribed (for the present year)	**a. ACEi/ ARB**		◉ Yes	◉ No
	b. SGLT2i		◉ Yes	◉ No
	c. Corticosteroids		◉ Yes	◉ No
	d. Cyclophosphamide	**i. Oral**	◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
		ii. Intravenous	◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
		Cumulative dose: ..... **grams**		
	e.Calcineurin Inhibitor	i. Cyclosporin	◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
		ii. Tacrolimus	◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
	f.Mycophenolate acid	i. Mycophenolate mofetil	◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
		i. Mycophenolate sodium	◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
	g. Azathioprine		◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
	h. Levamisole		◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
	i. Rituximab		◉ Yes ☐ **a.** On-going **b.** Start date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐ **c.** End date (dd/mm/yyyy): ☐☐-☐☐-☐☐☐☐	◉ No
	j. Plasma exchange		◉ Yes	◉ No
	k. Others, specify:			

7. Treatment outcome: *

a. Remission *Refer table below for definition

- Complete — i. Date: __-__-____
- Partial — ii. Date: __-__-____
- Not in remission

Definition

Complete remission:

- Reduction in proteinuria <0.5g/day (UPCR <0.5g/g or <50mg/mmol)
- Stabilization or improvement in kidney function

Partial remission:

- Reduction in proteinuria by at least 50% than baseline, and to <3g/day (UPCR <3g/g or 300mg/mmol)
- Stabilization or improvement in kidney function

b. Response to steroids (for MCD / primary FSGS)

- Steroid sensitive
  - i. Steroid dependent
  - ii. Frequently relapsing
- Steroid resistant
- No response
- Not applicable

c. Relapse

- Yes
  - i. Date of relapse: 1st relapse: __-__-____
    2nd relapse: __-__-____
    3rd relapse: __-__-____
  - ii. Number of relapse: .....
- No

8. Patient Outcome *

a. ESKD

i. **Date (dd/mm/yyyy):** __-__-____

b. Moved To Another Centre

i. **Date of last follow-up:**

ii **Name of new centre :** .....

c. Lost To Follow-Up

i. **Date of last follow up:**

ii. **Specify reason for dropping out, if any :**

d. Death

i. **Date of death:**

ii. **Cause of death:** *(Check where applicable)*

- Unknown
- Cardiovascular disease; eg. Ischaemic heart disease, cerebrovascular accident, pulmonary embolus etc
- Died suddenly at home; death not certified in hospital
- Infection, any type or site.
- Gastrointestinal haemorrhage
- Cancer
- Liver disease
- Patient refused further treatment; specify reason: .....
- Accidental death, specify .....
- Cause of death related to ESKD
- Other cause of death, specify .....

Specify details