

MRRB BIOPSY PROCEDURE FORM

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

| | |
|-------------|------------------------------------------|
| Office use: | <input style="width: 90%;" type="text"/> |
| Centre: | <input style="width: 90%;" type="text"/> |

Centre Name:

PATIENT PARTICULARS

Name : RN :

| | | |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Identification Card Number : | MyKad / MyKid: <input style="width: 100px;" type="text"/> - <input style="width: 100px;" type="text"/> - <input style="width: 100px;" type="text"/> | Old IC: <input style="width: 100px;" type="text"/> |
| | Other document No: <input style="width: 150px;" type="text"/> | Specify type (eg, passport, armed force ID): <input style="width: 150px;" type="text"/> |

SECTION 1 : BIOPSY DATA

1. Date Biopsy (dd/mm/yy): / - / - /

2. Encounter Type: In Patient elective In Patient emergency Day care

| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------|--------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------|-------------------------------------------------|---------------------------------------------------|
| <p>3. <input type="checkbox"/> Risk Factors (for Biopsy failure) (Check where applicable)</p> <p>↓</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> a. Previously failed biopsy</td> <td><input type="checkbox"/> c. Small kidney (< 9 cm)</td> </tr> <tr> <td><input type="checkbox"/> b. Obesity (BMI > 30)</td> <td><input type="checkbox"/> d. Uncooperative patient</td> </tr> </table> | <input type="checkbox"/> a. Previously failed biopsy | <input type="checkbox"/> c. Small kidney (< 9 cm) | <input type="checkbox"/> b. Obesity (BMI > 30) | <input type="checkbox"/> d. Uncooperative patient | <p>4. <input type="checkbox"/> Risk Factors (for complication) (Check where applicable)</p> <p>↓</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> a. Coagulopathic state</td> <td><input type="checkbox"/> c. On dialysis</td> </tr> <tr> <td><input type="checkbox"/> b. On anti-coagulation</td> <td><input type="checkbox"/> d. Small kidney (< 9 cm)</td> </tr> </table> | <input type="checkbox"/> a. Coagulopathic state | <input type="checkbox"/> c. On dialysis | <input type="checkbox"/> b. On anti-coagulation | <input type="checkbox"/> d. Small kidney (< 9 cm) |
| <input type="checkbox"/> a. Previously failed biopsy | <input type="checkbox"/> c. Small kidney (< 9 cm) | | | | | | | | |
| <input type="checkbox"/> b. Obesity (BMI > 30) | <input type="checkbox"/> d. Uncooperative patient | | | | | | | | |
| <input type="checkbox"/> a. Coagulopathic state | <input type="checkbox"/> c. On dialysis | | | | | | | | |
| <input type="checkbox"/> b. On anti-coagulation | <input type="checkbox"/> d. Small kidney (< 9 cm) | | | | | | | | |

5. Kidney Size On Ultrasound (cm): (Right) (cm) (Left) (cm) (Graft) (cm)

6. Biopsy Type: Percutaneous Biopsy Open Biopsy Transvenous Biopsy

7. Biopsy Procedure Data (* Applicable for Percutaneous Biopsy only)

| | First Doctor | Second Doctor |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ai. Category of doctor performed: | <input type="radio"/> Nephrologist <input type="radio"/> Other, specify: _____ <input type="radio"/> Nephrology Trainee <input type="radio"/> Renal Physician <input type="radio"/> Not available | <input type="radio"/> Nephrologist <input type="radio"/> Other, specify: _____ <input type="radio"/> Nephrology Trainee <input type="radio"/> Renal Physician <input type="radio"/> Not available |
| aii. Name of doctor Performed: <small>(You may choose not to provide name. Please tick 'Name not disclosed' check box. For trainee it is compulsory)</small> | <input type="checkbox"/> Name not disclosed | <input type="checkbox"/> Name not disclosed |
| b. Biopsy Technique: | | |
| i. Ultrasound biopsy: | <input type="radio"/> Yes → <input type="radio"/> Realtime guided <input type="radio"/> Not realtime guided <input type="radio"/> No | <input type="radio"/> Yes → <input type="radio"/> Realtime guided <input type="radio"/> Not realtime guided <input type="radio"/> No |
| ii. Plug biopsy: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not available | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not available |
| c. Biopsy Instrument: | <input type="radio"/> Biopsy gun <input type="radio"/> Trucut <input type="radio"/> Spring loaded biopsy needle | <input type="radio"/> Biopsy gun <input type="radio"/> Trucut <input type="radio"/> Spring loaded biopsy needle |
| d. Needle Size: | <input type="radio"/> 14G <input type="radio"/> 16G <input type="radio"/> 18G | <input type="radio"/> 14G <input type="radio"/> 16G <input type="radio"/> 18G |
| e. Direction Of Biopsy Needle: | <input type="radio"/> Perpendicular to kidney (Perpendicular) <input type="radio"/> Diagonally away from kidney (Cephalic) <input type="radio"/> Diagonally towards the kidney (Caudal) | <input type="radio"/> Perpendicular to kidney (Perpendicular) <input type="radio"/> Diagonally away from kidney (Cephalic) <input type="radio"/> Diagonally towards the kidney (Caudal) |
| f. Number Of Passes: | <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 | <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 |
| g. Core Obtained: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not available | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not available |
| h. Procedure Outcome : | <input type="radio"/> Successful <input type="radio"/> Failed → <input type="radio"/> Terminated <input type="radio"/> Refer 2nd Doctor | <input type="radio"/> Successful <input type="radio"/> Failed |

8. Complications (Check where applicable)

| | | | |
|-----------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------|
| <input type="radio"/> Yes → | a. <input type="checkbox"/> Bleeding → <input type="checkbox"/> Gross haematuria <input type="checkbox"/> Haematoma | c. <input type="checkbox"/> Infection | e. <input type="checkbox"/> Hypotension |
| <input type="radio"/> No | b. <input type="checkbox"/> Perirenal collection | d. <input type="checkbox"/> AVM | e. <input type="checkbox"/> Others : _____ |

9. Intervention Required

| | | | |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> Yes → <input type="radio"/> No | <p>a. Blood Transfusion</p> <input type="radio"/> Yes → No. of pints transfused _____ Lowest haemoglobin (g/dL) _____ <input type="radio"/> No | <p>b. Surgery</p> <p>(Check where applicable)</p> <input type="radio"/> Yes → <input type="checkbox"/> Nephrectomy <input type="radio"/> No <input type="checkbox"/> Others, specify _____ | <p>c. Radiology</p> <p>(Check where applicable)</p> <input type="radio"/> Yes → <input type="checkbox"/> Embolisation <input type="radio"/> No <input type="checkbox"/> Drainage <input type="checkbox"/> Others, specify _____ |
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