FORM 1

[See rule 3]

(To be completed by the prospective close blood related donor)

To be affixed and attested by Notary Public after it is affixed.

Name of the Donor……

Photograph of the Donor
(Attested by Notary Public)

Permanent address:-

……

…….. ……..

Tel: ……..

Present address:-

……

……..…….....

Tel:……..

Date of birth ……(day/month/year)

* National Identity Card number and Date of issue & place:……
(Photocopy attached)

and/or

* Form B of National Data Registration Authority (NADRA) of that family unit.

and/or

* Passport number and country of issue……
where available (Photocopy attached)

and/or

* Driving License number, Date of issue, licensing authority…….
where available (Photocopy attached)

and/or

* Other proof of identity and address …….

I hereby authorize removal for the therapeutic purposes/consent to donate my …… (state which organ) to my relative …….. (specify son / daughter / father / mother / brother / sister), whose name is ……. and who was born on ……(day/month/year) and whose particulars are as follows:

To be affixed and attested by Notary Public after it is affixed.

Photograph of the Recipient
(Attested by Notary Public)

* National Identity Card number and Date of issue & place:…… (Photocopy attached)

and/ or

* Form B of National Data Registration Authority (NADRA) of that family unit.

and/or

* Passport number and country of issue…….. where available (Photocopy attached)

and/ or

* Driving License number, Date of issue, licensing authority……. where available (photocopy attached)

and/or

* Other proof of identity and address ……

I solemnly affirm and declare that:

Sections 2, 3 and 11 of The Transplantation of Human Organs and Tissues Act, 2010 (VI of 2010) have been explained to me and I confirm that:

1. I understand the nature of criminal offences referred to in the sections.
2. No payment of money or money's worth as referred to in the Sections of the Ordinance has been made to me or will be made to me or any other person.
3. I am giving the consent and authorization to remove my ……..(organ) of my own free will without any undue pressure, inducement, influence or allurement.
4. I have been given a full explanation of the nature of the medical procedure involved and the risks involved for me in the removal of my ……..(organ). That explanation was given by ……(name of recognized transplant surgeon or physician).
5. I understand the nature of that medical procedure and of the risks to me as explained by that practitioner.
6. I understand that I may withdraw my consent to the removal of that organ at any time before the operation takes place.
7. I state that particulars filled by me in the form are true and correct to my knowledge and nothing material has been concealed by me.

…….. …….

Signature of the prospective donor Date

Note: To be sworn before Notary Public, who while attesting shall ensure that the person/persons swearing the affidavit(s) signs(s) on the Notary Register, as well.

FORM 2

[See rule 3]

(To be completed by the prospective spousal donor)

I ……

To be affixed and attested by Notary Public after it is affixed.

Photograph of the Donor
(Attested by Notary Public)

Permanent address:
…….. ……..
…… Tel: …….
Present address …… ……... ……...
…… Tel :……
Date of birth ……(day/month/year)

I authorize to remove for therapeutic purposes/consent to donate my ……
(state which organ) to my husband/wife…….. ……whose full name is ……. ……and who was born on ……(day/month/year) and whose particulars are

Photograph of the Recipient
(Attested by Notary Public)

To be affixed and attested by Notary Public after it is affixed.

* National Identity Card number and Date of issue & place:……
(photocopy attached)

and/or

* Passport number and country of issue……..
where available (photocopy attached)

and/or

* Driving License number, Date of issue, licensing authority…….
where available (photocopy attached)

and/or

* Other proof of identity and address …….

I submit the following as evidence of being married to the recipient:-

(a) a certified copy of a marriage certificate

or

(b) an affidavit of a 'close blood relative' confirming the status of marriage to be sworn before Class-I Magistrate/Notary Public.
(c) Family photographs / marriage photographs
(d) Letter from Nazim / Councilor certifying factum and status of marriage.
(e) Other credible evidence including the Form B of National Data Registration Authority (NADRA) of that family unit.

I solemnly affirm and declare that:

Sections 2, 3 and 11 of The Transplantation of Human Organs and Tissues Act, 2010 (VI of 2010) have been explained to me and I confirm that

1. I understand the nature of criminal offences referred to in the Sections.
2. No payment of money or money's worth as referred to in the Sections of the Ordinance has been made to me or will be made to me or any other person.
3. I am giving the consent and authorisation to remove my ……..(organ) of my own free will without any undue pressure, inducement, influence or allurement.
4. I have been given a full explanation of the nature of the medical procedure involved and the risks involved for me in the removal of my ……..(organ). That explanation was given by ……(name of recognized transplant surgeon or physician).
5. I understand the nature of that medical procedure and of the risks to me as explained by that practitioner.
6. I understand that I may withdraw my consent to the removal of that organ at any time before the operation takes place.
7. I state that particulars filled by me in the form are true and correct to my knowledge and nothing material has been concealed by me.

…….. …….

Signature of the prospective donor Date

Note : To be sworn before Notary Public, who while attesting shall ensure that the person /persons swearing the affidavit(s) signs(s) on the Notary Register, as well.

FORM 3

[See rule 3]

(To be completed by the prospective non close blood related donor)

Name of the Donor ……

To be affixed and attested by Notary Public after it is affixed.

Photograph of the Donor
(Attested by Notary Public)

Permanent address:
…….. ……..
…… Tel: …….
Present address ……... ……..
…… Tel :……
Date of birth ……(day/month/year)

* National Identity Card number and Date of issue and place:……..……
(photocopy attached)

and/or

* Passport number and country of issue……..……..
where available (photocopy attached)

and/or

* Driving License number, Date of issue, licensing authority……..……..…….
where available (photocopy attached)

and/or

* Other proof of identity and address ……

* Details of last three years income and vocation of donor……
……..

* A description of the relationship / interaction with the recipient in the past. ……
……

I hereby authorize to remove for therapeutic purposes/consent to donate my ……. (state which organ) to a person whose full name is ……. and who was born on ……(day/month/year) and whose particulars are.

To be affixed and attested by Notary Public after it is affixed.

Photograph of the Recipient
(Attested by Notary Public)

* National Identity Card number and Date of issue & place:…… (photocopy attached)

and/or

* Passport number and country of issue…….. where available (photocopy attached)

and/or

* Driving License number, Date of issue, licensing authority……. where available (photocopy attached)

and/or

* Other proof of identity and address …….

I solemnly affirm and declare that:

Sections 2, 3 and 11 of The Transplantation of Human Organs and Tissues Act, 2010 (VI of 2010) have been explained to me and I confirm that

1. I understand the nature of criminal offences referred to in the Sections.
2. No payment of money or money's worth as referred to in the Sections of the Ordinance has been made to me or will be made to me or any other person.
3. I am giving the consent and authorization to remove my ……..(organ) of my own free will without any undue pressure, inducement, influence or allurement.
4. I have been given a full explanation of the nature of the medical procedure involved and the risks involved for me in the removal of my ……..(organ). That explanation was given by ……(name of recognized transplant surgeon or physician).
5. I understand the nature of that medical procedure and of the risks to me as explained by that practitioner.
6. I understand that I may withdraw my consent to the removal of that organ at any time before the operation takes place.
7. I state that particulars filled by me in the form are true and correct to my knowledge and nothing material has been concealed by me.

…….. ……

Signature of the prospective donor Date

Note : To be sworn before Notary Public, who while attesting shall ensure that the person/persons swearing the affidavit(s) signs(s) on the Notary Register, as well.

* √ wherever applicable.

FORM 4

[See rule 4(1)(b)]

(To be completed by the recognized transplant surgeon or physician)

I, Dr……..possessing qualification of …….. registered as medical practitioner at serial no. ……..by the …….. Medical Council, certify that I have examined Mr./Mrs./Ms. ……..S/o, D/o, W/o ……..aged …… who has given informed consent about donation of the organ, namely…….. to Mr./Mrs./Ms ……..who is a 'close blood relative' of the donor/non close blood relative of the donor, who had been approved by the Evaluation Committee and that the said donor is in proper state of health and is medically fit to be subjected to the procedure of organ removal.

Place: …….

Date: …….

……
Signature of Doctor
Seal

To be affixed and attested by the doctor concerned. The signatures and seal should partially appear on photograph and document without disfiguring the face in photograph.

Photograph of the Donor
(Attested by doctor)

To be affixed and attested by the doctor concerned. The signatures and seal should partially appear on photograph and document without disfiguring the face in photograph.

Photograph of the recipient
(Attested by the doctor)

FORM 5

[See rule 4 (1](c)]

(To be completed by the recognized transplant surgeon or physician)

I, Dr……..possessing qualification of …….. registered as medical practitioner at serial no. ……..by the …….. Medical Council, certify that-

(i). Mr.. ……..S/o Mr. ……aged …… resident of …… and Mrs. ……..d/o., w/o. Mr. ……. aged …… resident of …….. are related to each other as spouse according to the statement given by them and their statement has been confirmed by means of following evidence before effecting the organ removal from the body of the said Mr/ Mrs/Ms. ……

Place: ……..

Date: ……..

……
Signature of Doctor
Seal

FORM 6

[See rule 4 (2)(a)]

(To be completed by person in his/her lifetime and willing to donate his/her organs/ tissues after death)

I, ……..s/o, d/o, w/o. Mr. …… aged…….

resident of …….. ……..….

in the presence of persons mentioned below hereby unequivocally authorize the removal of my organ/organs, namely, ……..…….. from my body after my death for therapeutic purposes.

……..

Signature of the donor

Date: …….

(Signature) ……..…….

(1). Mr./Mrs/Ms . ……..s/o, d/o, w/o, Mr. ……..…
aged …… resident of ……..
……Tel……

(Signature) ……..…….

(2). Mr./Mrs/Ms . ……..s/o, d/o, w/o, Mr. ……..…
aged …… resident of ……..
……Tel……
is a close blood relative to the donor as ……..

Date…….

FORM 7

[See rule 4 (2)(b)]

(To be filled by a person having lawful possession of the dead body)

I, ……..s/o, d/o, w/o. Mr. …… aged…….

resident of …….. ……..….

having lawful possession of the dead body of Mr./Mrs/Ms. …….

s/o./d/o/w/o. Mr. …… aged of …… resident of ……..

……. having known that the deceased has not expressed any objection to his/her organ/organs being removed for therapeutic purposes after his/her death and also having reasons to believe that no close blood relative of the said deceased person has objection to any of his/her organs being used for therapeutic purposes, authorize removal of his/her body organs, namely …….

……

Signature

Date……

Place……..

Person in lawful possession of the dead body

Address:…….

…….

FORM 8

[See rule 4 (3)(a)]

(To be filled by the Board of Medical Experts)

We, the following members of the Board of Medical Experts after careful personal examination, hereby certify that Mr/Mrs/Ms ……. aged ……. s/o, d/o., w/o. Mr. ……. resident of …… …….. is dead on account of permanent and irreversible cessation of all functions of the brain-stem. The tests carried out by us and the findings therein are recorded in the brain-stem death certificate annexed hereto.

Date…….. Signature…….

1. Medical Director or Medical Superintendent of the Hospital
2. A neurosurgeon/ neurophysician; and
3. An intensivist.

BRAIN-STEM DEATH CERTIFICATE

(A). Patient Details:

1. Name of the patient: Mr./Mrs./Ms. ……. s/o, d/o. w/o. ……..

Sex: ☐ Male ☐ Female Age …….. years

2. Address:……. …… Tel #.....

3. Hospital Number ……

4. Name and address of next of kin or person responsible for the patient (if none exist, this must be specified). …… resident of ……. ……

5. Has the patient or next of kin agreed to any transplant ? ……..

6. Is this a police case ? ☐ Yes ☐ No

(B) Pre-conditions:

1. Diagnosis: Did the patient suffer from any illness or accident that led to irreversible brain damage? Specify details .... Date and time of accident/onset of illness ..... Date and onset of no-responsible coma ?.....

2. Finding of Board of Medical Experts :

(1) The following reversible causes of coma have been excluded:

Intoxication (Alcohol)
Depressant Drugs
Relaxants (Neuromuscular blocking agents)
Others

	First Medical Examination		Second Medical Examination	
	1st	2nd	1st	2nd
Primary hypothermia				
Hypovolaemic shock				
Metabolic or endocrine disorders				
Tests for absent of brain stem functions				

2) Coma
3) Cessation of spontaneous breathing
4) Pupillary Size
5) Pupillary light reflexes
6) Doll's head eyes movement
7) Corneal reflexes (Both Sizes)
8) Motor response in any cranial nerve distribution, any responses to simulation of face, limb or trunk
9) Gag reflex
10) Cough (Tracheal)
11) Eye movements on caloric testing bilaterally
12) Apnoea tests as specified
13) Were any respiratory movements seen?

……..
Date and Time of first testing .....
Date and Time of second testing .....

This to certify that the patient has been carefully examined twice after an interval of about six hours and on the basis of findings recorded above,
Mr/Mrs/Ms. ..... is declared brain-stem dead.

1. Medical Director or Medical Superintendent of the Hospital
2. A neurosurgeon/ neurophysician; and
3. An intensivist.

NB.
The minimum time interval between the first testing and second testing will be six hours.

FORM 9

[See 4 (3)(b)]

(to be filled by either parent of dead child under 18 years)

I, Mr/Mrs/Ms. .....son of / wife of..... resident of.....

hereby authorize removal of the organ/organs namely.....for therapeutic purposes from the dead body of my son/daughter, Mr/Ms..... aged.....whose brain stem death has been duly certified in accordance with the law.

Signature.....

Name.....

Place.....

Date.....

FORM 10

[See 4 (1)(d)]

Application for Approval for Transplantation (Live Donor)

(To be completed by the proposed recipient and the proposed donor)

To be self attested across the affixed photograph	To be self attested across the affixed photograph
Photograph of the Donor (Self-attested)	Photograph of the recipient (Self-attested)

Whereas I …….s/o, d/o, w/o, ……... aged ……. residing at …….. have been advised by my doctor ……. that I am suffering from …….. …… and may be benefited by transplantation of …… into my body.

And whereas I ……s/o, d/o, w/o, ……... aged ……. residing at …….. by the following reason(s):-

a) by virtue of being a close blood relative i.e. _____

b) by reason of affection/attachment/other special reason as explained below :-

……
……
……

I would therefore like to donate my ……..to Mr./Mrs./Ms. . ……..…

We…… ……and ……. ……

(Donor) (Recipient)

hereby apply to Evaluation Committee for permission for such transplantation to be carried out.

We solemnly affirm that the above decision has been taken without any undue pressure, inducement, influence or allurement and that all possible consequences and options of organ transplantation have been explained to us.

Instructions for the applicants:-

1. Form 10 must be submitted along with the completed Form 1, or Form 2 or Form 3 as may be applicable.
2. The applicable Form i.e. Form 1 or Form 2 or Form 3 as the case may be, should be accompanied with all documents mentioned in the applicable form and all relevant queries set out in the applicable form must be adequately answered.
3. Laboratory reports of tissue typing.
4. The doctor's advice recommending transplantation must be enclosed with the application.
5. In addition to above, in case the proposed transplant is between non close blood relative, appropriate evidence of vocation and income of the donor as well as the recipient preferably for the last three years must be enclosed with this application. It is clarified that the evidence of income does not necessarily mean the proof of income tax returns, keeping in view that the applicant(s) in a given case may not be filing income-tax returns.
6. The application shall be accepted for consideration by the Evaluation Committee only if it is complete in all respects and any omission of the documents or the information required in the forms mentioned above, shall render the application incomplete.
7. A brief description of relationship / interaction in the past in case of non close blood relative.

We have read and understood the above instructions.

…….	……..
Signature of the Prospective Donor	Signature of Prospective Recipient
Date : …….	Date : ……..
Place : ……..	Place : …….

Form-11

[See Rule 11(1)]

APPLICATION FOR REGISTRATION / RECOGNITION OF INSTITUTION / UNIT FOR TRANSPLANTATION

Proforma to be completed and sent to Human Organ Transplant Authority (HOTA), 36 Aga Khan Road, Super Market, F-6/4, Islamabad, Fax No.051-9216107

Name of the Institution_____

Mailing Address_____

_____

Tel No._____Fax No._____Email_____

Name of the Head of the Institution_____

Designation_____Mailing Address_____

_____

Tel No._____Fax No._____Email_____

Status of Institution ☐ Public Sector ☐ Private ☐ Any other_____

Specialty units/departments accredited with CPSP/PMDC/University_____

S. No	Name of Specialty	Accreditation Authority	Name of Deptt. Heads With postgraduate qualifications
1.	Urology (Kidney Transplant)		
2.	Nephrology (Kidney Transplant)		
3.	GI and Hepatology (Liver & intestinal transplant)		
4.	Pulmonology (Lung Transplant)		
5.	Cardiology (Cardiac Transplant)		
6.	Hematology (BMT, Stem cell Transplant)		
7.	Ophthalmology (Corneal Transplant)		
8.	Radiology		
9.	Anesthesiology		
10.	Pathology		

(Please provide list of faculty in all Specialties with qualification and experience in Transplant as Annexure)

Total beds in the institution_____ Male_____Female_____Children_____

No. of OPDs_____Attendanece/year Male_____Female_____Children_____

Total beds in Transplant Unit:_____ Male_____Female_____Children_____

SUPPORT FACILITIES

Blood bank

Is the blood bank present? Yes No

If No please specify about storage _____

Are cross matching facilities available? Yes No

Are blood products available in house? Yes No

If No. what arrangements are in place for 24 hours availability _____
(Attach separate sheet if needed)

Laboratory

Please supply a list of tests, which are done in the laboratory in the following area.
(Attach separate sheet if needed)

Bio- Chemistry_____

Histopathology_____

Microbiology_____

Hematology_____

Immunology_____

Drug Monitoring _____

Radiology

Please furnish a list of radiological test routinely carried out in the Institution
(Attach separate Sheet if needed)

Specialized diagnostic facilities:

Ultrasound	Yes	☐	No	☐	MRI	Yes ☐	No ☐
CT Scan	Yes	☐	No	☐	Radioisotopes	Yes ☐	No ☐
Doppler	Yes	☐	No	☐	Portable X- Ray	Yes ☐	No ☐

Intensive Care Unit

If yes No. of ICU beds with high end monitoring and ventilation _____

Number of Monitors_____Total ventilator available_____

ABG machine in ICU Yes No Other Facilities _____

_____

Dialysis Yes No Availability of dialysis facility in ICU Yes NO

If yes No. of Dialysis machine in hospital_____Number of Sessions / day _____

If the following Specialties are not available in house please mention the arrangements for access at all time (Attach separate sheet if needed).

Cardiology_____

Pulmonology _____

GI / Hepatology_____

Infectious Disease_____

Neurology_____

Orthopedics_____

Operation Theatre and Anesthesiology

Please provide List of Equipment available for Transplant surgery as annexure.

Record Keeping

System of storage and retrieval of records_____

_____

Do you produce Annual Report? ☐ Yes ☐ No
(If yes please furnish the copy of annual report of last year)

How are the case records maintained? ☐ Manual ☐ Computerized

Library ☐ Yes ☐ No

Working days of the library_____Daily working hours_____
(Please provide the list of Textbooks of Transplant Sciences and Journals available in the Institution Department)

Research Facilities:

No. of in hand projects and title of research conducted by the faculty of the department:
(Attach separate sheet if needed)

Additional Essential Activities / Facilities

Nursing	Adequate number and of sufficient seniority to cover Transplant ward ICU
Medical Social Officer (Transplant Coordinator)	Depending on transplant activity minimum of 3 to help put pre transplant assessment and donor selection
Isolation Facility	1 to 2 rooms for isolation of patients when required
Pharmacy	Dedicated staff to respond to needs of transplant patients specially immunosuppressant, antibiotics and other drugs
Seminar Room	For daily patient related Meetings (AM and PM).Morbidity Mortality review, Clinical Audits
Other resources	Computers, Video films, internet access, multimedia Videoconferencing facilities with reference centre in future

Form-12

[See Rule 10(2)]

CERTIFICATE OF INTERIM REGISTRATION

In pursuance of Section 6, Sub-section (3) of "The Transplantation of Human Organs and Tissues Act, 2010 (VI of 2010)"_____Hospital has been accorded Interim Recognition for _____ transplantation.

2. Interim Recognition will NOT be a guarantee for formal recognition, which will be subject to detailed scrutiny of the hospital record, infrastructure, faculty and facilities available for transplant procedures. Hospital/institutions will facilitate the Inspection Team and provide free access to necessary information/record/data.

Administrator
Human Organ Transplant Authority (HOTA)

Official Seal

Form-13

[See Rule 11(2)]

CERTIFICATE OF REGISTRATION

In pursuance of section 6, sub-section (3) of "The Transplantation of Human Organs and Tissues Act , 2010 (VI of 2010)"_____ Hospital has been recognized for _____transplantation for a period of one year with effect from the date of issuance of this certificate. Notification in the Official Gazette will be published in due course.

Administrator
Human Organ Transplant Authority (HOTA)

Official Seal

FORM 14
[See Rule 10(3)]

PROFORMA FOR DONOR FOLLOW–UP

S. No._____ Date_____

Name_____s/w/d/o_____

Age_____Sex ☐ Male ☐ Female Occupation_____

Address_____

_____ Phone #_____

Education: ☐ Uneducated ☐ Primary School ☐ Secondary School

☐ Graduate ☐ Post-graduate ☐ Professional

Recipient's Name_____Relationship_____TX No._____

Site of Nephrectomy: ☐ Right ☐ Left Date of Nephrectomy_____

Habits: ☐ Cigarettes ☐ Pan ☐ Tobacco ☐ Gutka

☐ Naswar ☐ Bidis ☐ Alcohol

Rehabilitation: ☐ Working ☐ Not working

Reason for not working_____

Illnesses in intervening period: ☐ Liver Disease ☐ Tuberculosis ☐ UTI

☐ Malaria ☐ Hypertension ☐ Diabetes ☐ Surgery

☐ Others_____

Long Term Medications:

Name of Drugs	Dose	Duration

Family History: ☐ Diabetes ☐ Hypertension ☐ Renal Failure ☐ Angina/MI

Marital History: ☐ Married ☐ Unmarried ☐ Divorced

Number of wives_____ Total Children:_____ Males_____Females_____

Father: alive / expired **Mother:** alive / expired **Brothers:**_____ **Sisters:**_____

Obstetric History	**Menstrual History**
FTND _____LSCS_____	Menarche_____
Abortions_____	D/C_____
Still Births_____	Flow_____

Last Delivery_____ LMP_____

Dietary Recall

	Time	Diet
Breakfast		
Mid-Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Bed-Time Snack		

Cooking Medium ☐ Ghee ☐ Oil Atta _____ Exercise:_____

General Examination: Weight _____Height_____ BMI_____

☐ Oedema ☐ Lymph Nodes ☐ Thyroid ☐ Pallor ☐ Jaundice ☐ Clubbing

Blood Pressure: Lying_____ Sitting_____ Standing _____

Systemic Examination:

Cardiovascular System:

JVP_____ Heart Sounds_____Murmurs_____

Respiratory System:

Auscultation of Lung Fields_____Advent. Sounds _____

GI: Oral Cavity: Teeth_____Gums _____ Tongue_____

Abdomen: Liver_____ Spleen_____

Kidney _____Scar_____

Nervous System: Cranial Nerves_____ Reflexes_____

Coordination _____ Deep Reflexes_____

Psychoanalysis: ☐ Depression ☐ Satisfaction ☐ Fear

Doctor's Name_____ Signature_____

FORM-15
[See Rule 10(3)]

PROFORMA FOR RECIPIENT FOLLOW UP

Name_____ Age_____ Blood Group_____ HLA Typing_____ Date of Transplant_____

Date														
Weight														
Max temp														
B.P.														
Chest														
Graft														
Hb/Hct														
WBC														
BUN/Creat														
Na/K														
Sugar														
T.Bil/Direct														
GOT/GPT														
Urine Vol(L)														
U.RBC/WBC														
U.Proteins														
Culture														
X-ray														
U/S														
Prednisolone														
Azathioprine														
Cyclosporin														

FORM-16(a)

[See Rule 11(4)]

TRANSPLANT REGISTRY FORM

KIDNEY TRANSPLANT FIRST REPORT

_____

TRANSPLANT CENTRE

RECIPIENT_____ ___ ___ ____ Patient was on

(Name in full) Age Sex ABO ☐ Hemodialysis only

CAPD only ☐

Hemo + CAPD ☐

HLA-Type

Father/Husband_____ ____ ____ ____ Viral Status:

Name (in full) A B DR HCV ☐ pos ☐ neg

NIC Number_____ CMV ☐ pos ☐ neg

Address_____ EBV ☐ pos ☐ neg

_____

DONOR _____ ___ ___ ____ DONOR (Relationship)

Age Sex ABO Parent ☐

HLA-Type ☐ Sibling

Father/Husband_____ ____ ____ ____ ☐ Offspring

Name (in full) A B DR ☐ Other_____

☐ Deceased donor

NIC Number_____

Viral Status:

Address_____ HCV ☐ pos ☐ neg

_____ CMV ☐ pos ☐ neg

In case of deceased donor:

Donor Death: Treated With

☐ Trauma ☐ Dopamine ☐ Donor history of hypertension Donor Nephrectomy

☐ Cerebrovascular ☐ Noradrenalin ☐ Marginal donor for other reason_____ Left ☐

☐ Other_____ ☐ No treatment Specify Right ☐

Specify

☐ Non-heart beating donor

☐ Cold ischemia time_____Hrs.

TRANSPLANT

Transplant Date

___ _____ ____

Day Month Year

Graft No

☐ First

☐ Second

Immunosuppressive Protocol

Check combination:

☐ Cyclosporin

☐ Tacrolimus

☐ MMF

☐ AZA

☐ Steroids

☐ Others_____

Protocol includes induction:

ATG ☐

OKT3 ☐

IL-2antagonist ☐

Other immunosuppression

_____

Specify

CROSS MATCH RESULTS

Indicate results obtained with +(pos) or – (neg) leave rest blank

	Whole Lymphocytes 22^0C	T cells 37^0 or 22^0 5^0C	B cells (unabsorbed) 37^0 or 22^0 5^0C	Indicate where relevant Autologus X-Match against recipient cells T37/22 B37/22 B5	DTT X-match
Highest Reactive					
Serum					
Latest Serum					

Graft Function

☐ Immediate

☐ Delayed

Date reported:_____ Signature:_____

Signature_____ Head Transplant Centre

Member Evaluation Committee

Name: Name:

Note: In case donor/recipient is a married woman, Name of husband as well as father will be endorsed.

Fax/Mail to Administrator, Monitoring Authority Transplantation of Human Organs & Tissues, On the day of Transplantation on Fax: 051-9216107 followed by a copy by Courier/post.

FORM-16(b)
[See Rule 11(4)]

TRANSPLANT REGISTRY FORM

LIVER TRANSPLANT FIRST REPORT

_____
TRANSPLANT CENTRE

RECIPIENT_____ ___ ___ ____ **Viral Status:**
(Name (in full) Age Sex ABO HCV ☐ pos ☐ neg
CMV ☐ pos ☐ neg
Father/Husband_____ EBV ☐ pos ☐ neg
Name (in full)

NIC Number_____
Address_____
_____

Reasons/Indications for Transplant:

(1) Chronic viral hepatitis (hepatitis A, B, C and D)
(2) Acute fulminant liver failure
(3) Biliary Atresia
(4) Decompansated liver failure
(5) Cholestatic liver diseases
(6) Alcoholic liver disease
(7) Autoimmune chronic hepatitis
(8) Cryptogenic cirrhosis
(9) Inherited and metabolic diseases of the liver
(10) Metabolic and/or inherited disorders and liver trauma

Biochemistry:

Hemoglobin _____g/ 100ml
Thrombocytes ____10^9/ L
INR ____
ALAT ____ U/ L
ASAT ____ U/ L
Albumin _____g/ L
Bilirubin _____ u mol/ L
Creatinine _____ u mol/ L
Urea _____ mmol/ L
Hemodialysis _____ (N/ Y)

At Transplantation:

(i) Encephalopathy_____
(ii) Massive ascites _____
(iii) Variceal G.I. bleeding _____
(iv) Ventilator _____
(v) Artificial liver supp._____

Donor:

Father / Husband: _____
NIC Number: _____
Address:_____
_____

___ ____ ___
Age **Sex** **ABO**

Viral Status
HCV □ pos □ neg
CMV □ pos □ neg

Transplant Date
____ _____ ____
Day Month Year

□ Donor (Relationship)
□ Parent
□ Sibling
□ Offspring
□ Others

Transplant:

S. No____ □ First
□ Second

Date reported:_____ Signature:_____
Signature_____ Head Transplant Centre
Member Evaluation Committee
Name: Name:

Note: In case donor/recipient is a married woman, Name of husband as well as father will be endorsed.

**Fax/Mail to Administrator,
Monitoring Authority Transplantation of Human Organs & Tissues,
On the day of Transplantation on Fax: 051-9216107 followed by a copy by Courier/post.**

FORM-16(c)
[See Rule 11(4)]

TRANSPLANT REGISTRY FORM
STEM CELL TRANSPLANT FIRST REPORT

Transplant Centre

Name of Physician

Recipient name

Father's name

NIC number

Address

Donor's name (if applicable)

Father's name

Relationship of recipient

Indication fir transplant

Source of stem cells

i) Adult stem cells:
   a. Bone marrow
   b. Blood
   c. Tissue

If source is blood or tissue please mention by what process stems were harvested.

Is this harvesting procedure	experimental	YES	NO
	accepted norm	YES	NO

ii) Cord Blood Cells:
iii) Embryonal stem cells: Derived either from blastocysts or foetal tissues

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Date reported:_____ Signature:_____
Signature_____ Head Transplant Centre
Member Evaluation Committee

Name: Name:

Note: In case donor/recipient is a married woman, Name of husband as well as father will be endorsed.

**Fax/Mail to Administrator,
Monitoring Authority Transplantation of Human Organs & Tissues,
On the day of Transplantation on Fax: 051-9216107
followed by a copy by Courier/post.**

Form-17
[See Rule 12(2)]

CERTIFICATE OF RENEWAL OF REGISTRATION (For Transplantation of Human Organs and Tissues)

In pursuance of section 6, sub-section (3) of "The Transplantation of Human Organs and Tissues Act, 2010 (VI of 2010)"_____ Hospital has been accorded renewal of registration for a further period of one year with effect from the date of issuance of this certificate for _____ transplantation. Notification in the Official Gazette will be published in due course.

Administrator
Human Organ Transplant Authority (HOTA)

Official Seal