

**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:

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
- \* 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)

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

I .....

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)

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 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.

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 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.

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)

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	
	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>
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 Sides)
- 8) Motor response in any cranial nerve distribution, any responses to stimulation 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.....

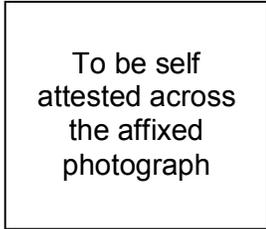
Name.....

Place.....

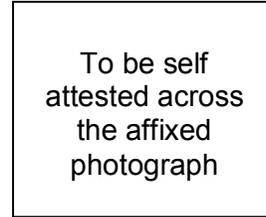
Date.....

**FORM 10**  
[See 4 (1)(d)]

**Application for Approval for Transplantation (Live Donor)**  
(To be completed by the proposed recipient and the proposed donor)



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 allurements 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 \_\_\_\_\_

<b>S. No</b>	<b>Name of Specialty</b>	<b>Accreditation Authority</b>	<b>Name of Deptt. Heads With postgraduate qualifications</b>
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**

FTND \_\_\_\_\_ LSCS \_\_\_\_\_

Abortions \_\_\_\_\_

Still Births \_\_\_\_\_

**Menstrual History**

Menarche \_\_\_\_\_

D/C \_\_\_\_\_

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-16(a)**

[See Rule 11(4)]

**TRANSPLANT REGISTRY FORM  
KIDNEY TRANSPLANT FIRST REPORT**

**TRANSPLANT CENTRE**

**RECIPIENT**

(Name (in full))  
CAPD only  
Hemo + CAPD

Age Sex ABO

Patient was on  
Hemodialysis only

HLA-Type

Father/Husband  
Name (in full)

A B DR

Viral Status:

HCV  pos  neg  
CMV  pos  neg  
EBV  pos  neg

NIC Number  
Address

**DONOR**

Age Sex ABO

Parent

DONOR (Relationship)

HLA-Type

Father/Husband  
Name (in full)

A B DR

Sibling  
Offspring  
Other  
Deceased donor

NIC Number

Address

Viral Status:

HCV  pos  neg  
CMV  pos  neg

**In case of deceased donor:**

Donor Death:

Trauma  
 Cerebrovascular  
 Other  
Specify

Treated With

Dopamine  
 Noradrenalin  
 No treatment

Donor history of hypertension  
 Marginal donor for other reason

Specify

Donor Nephrectomy

Left   
Right

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 T cells B cells (unabsorbed)  
Highest 22°C 37° or 22° 5°C 37° or 22° 5°C  
Reactive

Indicate where relevant  
Autologus X-Match  
against recipient cells  
T37/22 B37/22 B5

DTT  
X-match

Graft Function

Immediate  
 Delayed

Serum

Latest Serum

Date reported: \_\_\_\_\_ Signature: \_\_\_\_\_  
Signature \_\_\_\_\_  
Member Evaluation Committee

Head Transplant Centre

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.**

**TRANSPLANT REGISTRY FORM**  
**LIVER TRANSPLANT FIRST REPORT**

\_\_\_\_\_  
TRANSPLANT CENTRE

**RECIPIENT**

\_\_\_\_\_  
(Name (in full))

\_\_\_\_\_  
Age      Sex      ABO

**Viral Status:**

HCV  pos  neg  
CMV  pos  neg  
EBV  pos  neg

Father/Husband \_\_\_\_\_  
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) Decompensated 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<sup>9</sup>/ 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

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

**Viral Status**

HCV  pos  neg  
CMV  pos  neg

Transplant Date

\_\_\_\_\_  
Day      Month      Year

**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.**

**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 for 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 \_\_\_\_\_  
Member Evaluation Committee

Head Transplant Centre

Name:

Name:

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

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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**