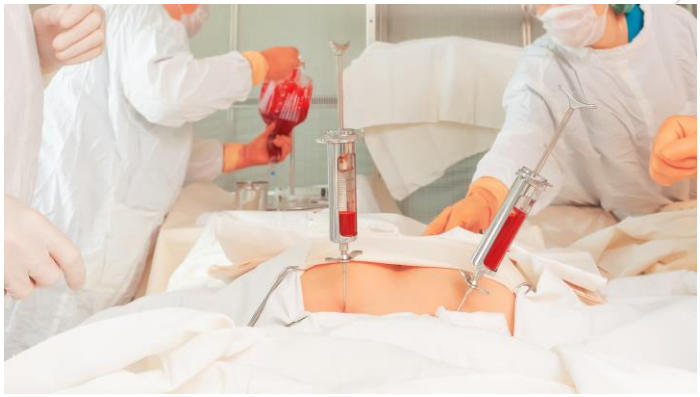
Bone Marrow Evaluation R-Form

(2018)



Guidelines for the Team Leader

1. Please Filled the R-form completely.
2. Please make sure the Presence of all the representatives of Regional Network Committee.
3. Please make sure any observations /comments apart from those fields in R-Form sent separately to office of PHOTA and these observations cannot be base to Reject or Recommend the case.
4. Please make sure Registration should be strictly on fields included in the R-Form.
5. Please make sure the Signature/initial of Commissioner's Representative on each page of R-form.

Name of Hospital: _____

Date of visit: _____

Purpose of Visit: Registration of Bone Marrow Transplantation.

Signature of Commissioner's Representative_____

Sr. #	Items checked	Yes	No
1.	**Accreditation licensing by Punjab Health Care Commission (PHCC)***		
2.	**Disposal of Medical Waste Agreement***		
3.	**Tissue Typing facility in house or outsourced (MoU required)***		
4.	**Valid Experience Certificates, Degree or other certificates of entire Medical Team related to Organ Transplantation***		
5.	**Performa of PHOTA (filled and complete)***		
6.	**Last Visit / Audit report of PHCC (Punjab Health Care Commission)***		
	Above six mentioned list of items mandatory to proceed further. If any one of them is mentioned NO. Do not Proceed further.		
7.	Record / one year list of donors recipient with contact numbers		
8.	Notification of Infectious Control Committee and its proceedings		
9.	Minutes of Internal Organ Transplant Committee of Institution / hospital		
10.	Previous approval by PHOTA		

Comments (if any): _____

_____

RECOMENDED	NOT RECOMMENDED	RECOMMENDED WITH MINOR CHANGES	RE-VISIT

**Mandatory to Tick ✓ above mentioned Options.

Sr. #	Name of visiting officer	Signature
1.	Commissioner of the Division (Chairman)	
2.	Regional Police Officer or His representative (Member)	
3.	Principal/s of Medical College/s at Divisional level (Member)	
4.	Director Health Services (Member/Secretary)	
5.	One expert of relevant field (Co-opted Member)	

Constitution of Regional Network at Division level According to Notification NO.S.O (H&D) 7-7/2012 of "The Punjab Human Organs and Tissues Act 2012"

Commissioner_____

Signature of Commissioner's Representative_____

CHECKLISTS OF ESSENTIAL STANDARDS FOR GRANT OF CERTIFICATE OF REGISTRATION TO MEDICAL INSTITUTIONS AND HOSPITAL BONE MARROW TRANSPLANTATION

(A) SOPs and PROCESS DOCUMENTATION:

PROTOCOLS AND SOPS, FOR EACH OF THE FOLLOWING SEGMENTS WITH NAMES AND QUALIFICATIONS OF PERSONS RESPONSIBLE TO CARRY THEM OUT

Sr. #	SOPs for	Person responsible to implement SOP	Qualification of the person	Yes / No
1.	Donor selection and assessment			Yes ☐ No ☐
2.	Evaluation committee – availability of finances , and initial screening			Yes ☐ No ☐
3.	HLA and other Tissue matching investigations (MoU required if it is out sourced)			Yes ☐ No ☐
4.	Evaluation of donor- recipient pair			Yes ☐ No ☐
5.	Pre- procedure care/nutrition/ psychotherapy			Yes ☐ No ☐
6.	Procedure protocols			Yes ☐ No ☐
7.	Post-procedure SOPs			Yes ☐ No ☐
8.	Isolation room SOPs			Yes ☐ No ☐
9.	infection control SOPs for area/surfaces/space/utilities			Yes ☐ No ☐
10.	Mishap reporting SOP, Vigilance & Surveillance, internal audit system			Yes ☐ No ☐
11.	Processes supervision SOPs			Yes ☐ No ☐
12.	Certification from 3rd party clearance (Health Care commission / PHOTA)			Yes ☐ No ☐
13.	Does the hospital administrator know that he is personally responsible for implementation of protocols and procedures			Yes ☐ No ☐

Signature of Commissioner's Representative_____

(B) MANPOWER REQUIREMENTS:

1) Clinical programme Director:

A physician who has received certification in one or more of following specialities; Clinical haematology, Medical oncology, Paediatric / adult immunology, Paediatric haematology-oncology. The director should have two years' experience of training in BMT Centre.

Particulars and evidence of Lead Transplant Physician / Surgeon provided as detailed below:

Name	Medical Qualification	Permanent Employee
		Yes ☐ No ☐

Name _____ Date of Birth _____

Qualification: FCPS, MD, FRCPath, FRCP, FRCS, MRCPCH, Diplomat American Board or equivalent _____

CNIC _____ PMDC No. _____

Cell No _____ E-Mail _____

Residential Address _____

Official Address _____

i.	Registered with PMDC (valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualifications registered with PMDC	*Enclosed* ☐	*Not enclosed* ☐
iii.	Originals certificates required in serial No. i & ii have been examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not submitted* ☐

Signature of Commissioner's Representative_____

2. Attending Physician - General paediatrics:

No. of Consultants of concerned speciality: (Please Tick ✓ the check box)
☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Name ☐ Date of Birth ☐

Qualification: MRCP, FRCP, FCPS, MRCPCH, MD, Diplomat American Board or equivalent ☐

CNIC ☐ PMDC No. ☐

Cell No. ☐ E-Mail ☐

Residential Address ☐

Official Address ☐

		Yes	No
i.	Registered appropriately with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in i & ii have been examined.	☐	☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not Submitted* ☐

3. Attending Physician (Transplant Medical Specialist):

Appropriately licensed for one or more of: clinical haematology/ paediatric haematology-oncology / Adult or paediatric immunology.

No. of Consultants / Specialists: (Please Tick ✓ the check box)
☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultant Transplant Specialist Medical:

Name ☐ Date of Birth ☐

Qualification: MRCP, FRCP, FCPS, MRCPCH, MD, Diplomat American Board or equivalent ☐

Signature of Commissioner's Representative_____

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered with PMDC (valid certificate enclosed)	☐ *Enclosed*	☐ *Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
iii.	Originals certificates required in i & ii have been examined.	☐	☐
iv.	Original experience certificate from competent authority	☐ *Submitted*	☐ *Not Submitted*

4. Attending Physician: (Oncologist)

Appropriately licensed for one or more of: medical oncology/ paediatric haematology/ paediatric oncology.

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultant Attending Physician (Oncologist):

Name | Date of Birth

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered with PMDC (valid certificate enclosed)	☐ *Enclosed*	☐ *Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
iii.	Originals certificates required in i & ii have been examined.	☐	☐
iv.	Original experience certificate from competent authority	☐ *Submitted*	☐ *Not Submitted*

Signature of Commissioner's Representative_____

5) Intensivist:

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultant Intensive care:

Name ☐ Date of Birth ☐

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent ☐

CNIC ☐ PMDC No. ☐

Cell No. ☐ E-Mail ☐

Residential Address ☐

Official Address ☐

i.	Registered with PMDC (valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualifications registered with PMDC	*Enclosed* ☐	*Not Enclosed* ☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not Submitted* ☐

6) Anaesthetist:

No. of Consultants / Specialists: (Please ✓ Tick the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultant Anaesthesia:

Name ☐ Date of Birth ☐

Qualification: FRCA, FCPS, MS, Diplomat American Board or equivalent ☐

CNIC ☐ PMDC No. ☐

☐ ☐

Signature of Commissioner's Representative_____

Cell No. E-Mail

Residential Address

Official Address

		Yes	No	Enclosed	Not Enclosed
i.	Registered with PMDC (valid certificate enclosed)	☐	☐		
ii.	Attested copy of specialist qualifications registered with PMDC			☐	☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	☐	☐		
iv.	Original experience certificate from competent authority			*Submitted* ☐	*Not Submitted* ☐

7) Clinical Pharmacist:

No. of Pharmacists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Clinical Pharmacist provided as detailed below:

Name Date of Birth

Qualification: D. Pharmacy or equivalent qualification

CNIC Reg. No.

Cell No. E-Mail

Residential Address

Official Address

		Yes	No	Enclosed	Not Enclosed
i.	Registered with Pharmacy Council (valid certificate enclosed)	☐	☐		
ii.	Attested copy of specialist qualification registered with Pharmacy Council.			☐	☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	☐	☐		

Signature of Commissioner's Representative_____

iv. Original experience certificate from competent authority *Submitted* ☐ *Not Submitted* ☐

8) Pathologist (Microbiologist):

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultant Pathology (Microbiology):

Name | Date of Birth

Qualification: FRCPath, FCPS, MD, Diplomat American Board or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

i. Registered with PMDC (valid certificate enclosed) Yes ☐ No ☐

ii. Attested copy of specialist qualifications registered with PMDC *Enclosed* ☐ *Not Enclosed* ☐

iii. Originals certificates required in Sr. No. i & ii have been examined. Yes ☐ No ☐

iv. Original experience certificate from competent authority *Submitted* ☐ *Not Submitted* ☐

Signature of Commissioner's Representative_____

9) Pathologist (Haematologist):

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultant Pathology (Haematology):

Name | Date of Birth

Qualification: FRCPath, FCPS, MD, Diplomat American Board or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

i. Registered with PMDC (valid certificate enclosed) Yes ☐ No ☐

ii. Attested copy of specialist qualifications registered with PMDC *Enclosed* ☐ *Not Enclosed* ☐

iii. Originals certificates required in Sr. No. i & ii have been examined. Yes ☐ No ☐

iv. Original experience certificate from competent authority *Submitted* ☐ *Not Submitted* ☐

10) Radiologist:

No. of consultants: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultant Radiology:

Name | Date of Birth

Qualification: FRCR, FCPS, MD, Diplomat American Board or equivalent

CNIC | Reg. No.

Cell No. | E-Mail

Signature of Commissioner's Representative_____

Residential Address

Official Address

i.	Registered with PMDC/(valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualification registered with PMDC	*Enclosed* ☐	*Not Enclosed* ☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not Submitted* ☐

11) Nutritionist:

(Please Tick ✓ the check box) Yes ☐ No ☐

Particulars and evidence of Nutritionist provided as detailed below:

Name Date of Birth

CNIC E-Mail

Cell No.

Residential Address

Official Address

i.	Attested copy of Diplomas / certificate of training	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of experience certificate in handling patients	*Submitted* ☐	*Not submitted* ☐
iii.	Attested copy of Experience certificate	*Submitted* ☐	*Not submitted* ☐

Signature of Commissioner's Representative_____

12) Transplant Coordinators/Bioethics Officer:

(Please Tick ✓ the check box) Yes ☐ No ☐

Particulars and evidence of Transplant Coordinator provided as detailed below:

Name | Date of Birth

Qualification: MBBS, MSc & Other:

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

i. Registered with PMDC in case of medical practitioner Yes ☐ No ☐

ii. Evidence of experience / courses to support essential standards requirement and job description. *Submitted* ☐ *Not submitted* ☐

13) Senior Nursing Staff: The nursing staff should be trained in haematology/ oncology patient care, administration of blood products, cellular products, recognition of complications and end of life care.

13 a) Senior Nursing Staff-1:

Name	**Qualification**	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-1 provided as detailed below:

Name | Date of Birth

CNIC | Reg. No.

Cell No. | E-Mail

Signature of Commissioner's Representative_____

Residential Address	
Official Address	

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant preoperatively.	*Submitted* ☐	*No submitted* ☐
iv.	Experience / Training certificate in handling patients in oncology	*Submitted* ☐	*Not Submitted* ☐
v.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

13 b) Senior Nursing Staff-2:

Name	**Qualification**	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-2 provided as detailed below:

Name		Date of Birth	
CNIC		Reg. No.	
Cell No.		E-Mail	
Residential Address			
Official Address			

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant preoperatively.	*Submitted* ☐	*No submitted* ☐
iv.	Experience / Training certificate in handling patients in oncology	*Submitted* ☐	*Not Submitted* ☐
v.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

Signature of Commissioner's Representative_____

13 c) Senior Nursing Staff-3 / ICU Sister:

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-3 provided as detailed below:

Name ☐ Date of Birth ☐

CNIC ☐ Reg. No. ☐

Cell No. ☐ E-Mail ☐

Residential Address ☐

Official Address ☐

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant preoperatively.	*Submitted* ☐	*No submitted* ☐
iv.	Experience / Training certificate in handling patients in oncology	*Submitted* ☐	*Not Submitted* ☐
v.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

14) Data Entry / Computer Operator:

(Please Tick ✓ the check box) Yes ☐ No ☐

Particulars and evidence of Data Entry / Computer Operator provided as detailed below:

Name ☐ Date of Birth ☐

CNIC ☐ E-Mail ☐

Cell No. ☐

Residential Address ☐

Signature of Commissioner's Representative_____

Official Address

i. Attested copy of Graduate qualification — *Submitted* ☐ *Not submitted* ☐

ii. Attested copy of Microsoft office certificate. — *Submitted* ☐ *Not submitted* ☐

iii. Attested copy of Experience certificate — *Submitted* ☐ *Not submitted* ☐

15) Laboratory Technicians:

15 a) Laboratory Technician-1:

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of Laboratory Technician-1 provided as detailed below:

Name | Date of Birth

CNIC | E-Mail

Cell No.

Residential Address

Official Address

i. Attested copy of Diplomas / certificate of training in Laboratory — *Submitted* ☐ *Not submitted* ☐

ii. Attested copy of experience certificate in Laboratory training — *Submitted* ☐ *Not submitted* ☐

iii. Attested copy of experience certificate in blood banking and Attested copy of training in bone marrow transplant unit — *Submitted* ☐ *Not submitted* ☐

15 b) Laboratory Technician-2:

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of Laboratory Technician-2 provided as detailed below:

Signature of Commissioner's Representative_____

Name | Date of Birth

CNIC | E-Mail

Cell No.

Residential Address

Official Address

		Submitted	*Not submitted*
i.	Attested copy of Diplomas / certificate of training in Laboratory	☐	☐
ii.	Attested copy of experience certificate in Laboratory training	☐	☐
iii.	Attested copy of experience certificate in blood banking & Attested copy of training in bone marrow transplant unit	☐	☐

15 c) Laboratory Technician-3:

Name	**Qualification**	Yes	No
		☐	☐

Particulars and evidence of Laboratory Technician-3 provided as detailed below:

Name | Date of Birth

CNIC | E-Mail

Cell No.

Residential Address

Official Address

		Submitted	*Not submitted*
i.	Attested copy of Diplomas / certificate of training in Laboratory	☐	☐
ii.	Attested copy of experience certificate in Laboratory training	☐	☐
iii.	Attested copy of experience certificate in blood banking & Attested copy of training in bone marrow transplant unit	☐	☐

Signature of Commissioner's Representative_____

C) EQUIPMENT REQUIREMENT:

The transplant centre will have the support of hospital's microbiology, chemical pathology and haematological laboratories with minimum of following equipment:

1 Routine Laboratory Services:

	Availability (Certificate to be provided by the hospital)		**Functionality** (Certificate to be provided be the hospital)	
Hematology Autoanalyzer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Chemistry Analyzer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Electrolyte Analyzer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Blood Gas Analyzer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
ELISA Plate reader and washer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Facilities for routine microbiological tests	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Fridge at 4 C ^{o}	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Microscopes	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Roller Mixers	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Automatic pipettes	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐

Signature of Commissioner's Representative_____

2) Radiology Department:

	Availability (Certificate to be provided by the hospital)		Functionality (Certificate to be provided be the hospital)	
	Present	Not Present	Functioning	Not Functioning
X-ray machine / Digital X-ray / Mobile X-ray	☐	☐	☐	☐
Doppler ultrasound machine with needle guide	☐	☐	☐	☐

3) Anesthesia Department:

	Availability (Certificate to be provided by the hospital)		Functionality (Certificate to be provided be the hospital)	
	Present	Not Present	Functioning	Not Functioning
Anaesthesia machine and its affiliated functions (preferably with computerized ventilator) Machine with central supply of oxygen and oxygen cylinder Vaporizer (Cervoflurance, Isoflurane) Oxygen failure arm N2O cut of device	☐	☐	☐	☐
Anti-hypoxic device Ventilator (Digital or manual) with following features: Gas/ electric driven Tidal volume adjustment Ventilation mode adjustment Inspiratory / expiratory ratio Inspiratory flow rate	☐	☐	☐	☐

Signature of Commissioner's Representative_____

Monitoring devices:	**Present**	**Not present**	**Functioning**	**Not Functioning**
ECG	☐	☐	☐	☐
Pulse oximeter	☐	☐	☐	☐
End Tidal CO_2	☐	☐		
Non-invasive BP monitor	☐	☐	☐	☐
Invasive BP monitor	☐	☐	☐	☐
Temperature monitor (surface and Core)	☐	☐	☐	☐
Central venous pressure monitor	☐	☐	☐	☐
Suction Machine				
Warming Devices:	☐	☐	☐	☐
Fluid warming cabinet				
Transfusion warmer				
Warming mattress				
Warming Blanket				
Worm air bler				

***Disposables / Materials*:**

Airway management gadgets (Laryngoscope, Bougie, Styllets, Endotracheal tubes, Laryngeal masks, Fiberopticlaryingo scope etc)	Provided ☐	Not Provided ☐
Reserve gas cylinders (O_2, N_2O, Air)	Provided ☐	Not Provided ☐
Infusion pumps	Provided ☐	Not Provided ☐
Syringe pumps	Provided ☐	Not Provided ☐
Nerve stimulators	Provided ☐	Not Provided ☐
CVP catheters (double and triple lumen)	Provided ☐	Not Provided ☐

Signature of Commissioner's Representative_____

4) Pharmacy Department:

The pharmacy must provide the following minimum requirements.

Disposables/ Materials:

IVanesthetic agents Thiopentone Propofol	Provided ☐	Not Provided ☐
Narcotics	Provided ☐	Not Provided ☐
Non depolarizer muscle relaxants	Provided ☐	Not Provided ☐
Inotrops Dopamine Dobutamine Phenyl ephrine Adrenaline Nor epinephrine	Provided ☐	Not Provided ☐
Beta Blockers Inj. Labetalol Inderal)	Provided ☐	Not Provided ☐
Vasodilators GTN Hydralazine Nitro Prusside	Provided ☐	Not Provided ☐
Local anesthetic Bupivaccin Xylocaine	Provided ☐	Not Provided ☐
Naloxone	Provided ☐	Not Provided ☐
Calcium chloride	Provided ☐	Not Provided ☐
Mg SO_4	Provided ☐	Not Provided ☐
Immunosuppressive drugs.	Provided ☐	Not Provided ☐
Urine bags, Catheters	Provided ☐	Not Provided ☐
Chemotherapeutic agents	Provided ☐	Not Provided ☐
Anti-biotic, Anti-viral and Anti-fungal agents	Provided ☐	Not Provided ☐
Endotracheal tubes, Laryngeal masks, Central Venous Catheters	Provided ☐	Not Provided ☐

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5) The transplant unit requires:

5 a) Intensive Care Unit:

At least four bedded facility for 48 hours intensive care	Provided ☐	Not Provided ☐
Maneuverable bed equipped with facility for cardiac monitoring, invasive monitoring, NIBP and Oximetry.	Provided ☐	Not Provided ☐
Foot tables	Provided ☐	Not Provided ☐
Stand by ventilator (at least two)	Provided ☐	Not Provided ☐
Basic resuscitation trolley Complete in every respect. Defibrillator	Provided ☐	Not Provided ☐
ECG machine	Provided ☐	Not Provided ☐
Portable IV stands		
Stretcher & wheel chair	Provided ☐	Not Provided ☐
Sharps box and biohazard bags		
VCP manometer	Provided ☐	Not Provided ☐
Infusion pumps (8-10)		
PPE (disposable)	Provided ☐	Not Provided ☐
HVAC unit with HEPA filters		
Full Isolation facilities with entry control Positve pressure Hepa filtered air conditioning Parents area with both way	Provided ☐	Not Provided ☐

5 b) Operation Theatre Department: with two adjustable tables and a 10 feet × 12 feet recovery room.

Minimum Surgical Instrument required for bone marrow transplant

i. Disposable bone marrow aspiration and biopsy needle G 9 and 11	Provided ☐	Not Provided ☐

Signature of Commissioner's Representative_____

ii. Disposable paediatric bone marrow aspiration and biopsy needle G 13	Provided ☐	Not Provided ☐
iii. Disposable syringes 10 CC and 50 CC	Present ☐	Not Present ☐

C) Apheretic Facility: 10 × 12 feet with good ventilation and light source.	Present	Not Present
Necessary instrument : apheretic machine	☐	☐
D) Stem cell processing laboratory: 12 feet × 12 feet. It should have good light, ventilation and sterile environment	☐	☐
Essential :		
Biosafety cabinet	☐	☐
waterbath		
Plasma exatractor		
Cryotranspoter (-80 o C)or liquid nitrogen dry shipper	☐	☐
Refrigerator		
Centrifuge (with carriers to hold 600 ml bags)		
Tubing sealer	☐	☐
Micropipettes (100 and 1000 microlitre)		
Balance scale	☐	☐
Freezer (-70 ° C)		
Tubbing stipper	☐	☐
Refrence thermometer		
Desired :		
Sterile connecting device	☐	☐
Label printer	☐	☐
Controlled rate freezer		
Liquid nitrogen freezer	☐	☐
CO_2 incubator		
Hemocytometer	☐	☐
Laboratory supplies	☐	☐
Cryobags (50,250, 500 ml)		
Cryovials/ microtubules	☐	☐
Transfer packs (300, 600 ml)		
Safety needle coup;ers	☐	☐
Conical tubes (15,50, 175 ml)		
Tube racks		
Syringes (1,3,20,50 ml)	☐	☐
Biohazard bags for sharp containers, waste materials		

Signature of Commissioner's Representative_____

5 **BMT Unit Rooms:**

In each room:	Provided	Not Provided
Manoeuvrable bed	☐	☐
ECG machine in BMT Unit	☐	☐
Pulse Oximeter & NIBP	☐	☐
Weighing Machine	☐	☐
Portable IV stands	☐	☐
Wheel Chairs	☐	☐
X-Ray Illuminator	☐	☐
Easy chairs for patients and footsteps,	☐	☐
Nebulizer	☐	☐
Spirometer	☐	☐
Sharps box and biohazard bags	☐	☐
Suction machine	☐	☐
Laryngoscopes	☐	☐
Procedure sets	☐	☐
PPE disposable	☐	☐
HVAC unit with HEPA filters		
Full Isolation facilities with entry control Positve pressure Hepa filtered airconditioning Parents area with both way	☐	☐
electronic/physical vision facility	☐	☐
Staff (Receptionist, Ward Boys, Ayas, Sweepers, Peons)	☐	☐

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D) SPECIALIZED SERVICES AND FACILITIES:

The hospital administrator will ensure satisfactory provision of the following services and facilities.

1) Laboratory Service:

The Haematology, Microbiology, Chemical Pathology and Histopathology Sections must be available and functional.

i.	**HEMATOLOGY:**	Yes ☐	No ☐
	Routine Blood Counts / Peripheral films		
	Flow cytometer	Present ☐	Not Present ☐
	Haemoglobin electrophoresis		
	Automated coagulometer		
ii.	**Microbiology:**	Yes	No
	Culture and Sensitivity for aerobic, anaerobic and fungal cultures	☐	☐
iii.	**Chemical pathology:**	Yes ☐	No ☐
	Biochemical Investigations		
	Organ Function Tests	Yes ☐	No ☐
	24 hours urinary analysis	Yes ☐	No ☐
iv.	**Histopathology:**	Provided ☐	Not Provided ☐
	Routine processing and reporting of biopsy		
	Cytology specimens process and reporting	Provided ☐	Not Provided ☐
v.	**Immunology:**	Provided ☐	Not Provided ☐
	Tissue typing		
	Immunosuppressive drug monitoring	Provided ☐	Not Provided ☐
	Molecular diagnostic facilities	Provided ☐	Not Provided ☐
	24 hours availability of laboratory	Yes ☐	No ☐

2) Operation Theatre And Anesthesia Department:

i.	Minimum two operating theatres	Provided ☐	Not Provided ☐
ii.	Separate theatre available for transplant procedures only	Provided ☐	Not Provided ☐
iii.	State of sterilization:	Provided	Not Provided
	Autoclave	☐	☐
	Operating instructions	Provided ☐	Not Provided ☐
	Maintenance certificate	Provided ☐	Not Provided ☐

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	Quality control on efficacy of sterilization	Provided ☐	Not Provided ☐
iv.	SOPs of Operation Theatre	Provided ☐	Not Provided ☐
v.	Theatre personnel: Minimum of 2 trained staff Nurses	Provided ☐	Not Provided ☐
	Minimum of 4 Operation Theatre Assistants	Provided ☐	Not Provided ☐
	Minimum of 6 ancillary staff	Provided ☐	Not Provided ☐
vi.	Minimum of 2 electronically operated operation tables with high quality light devices	Provided ☐	Not Provided ☐
vii.	Minimum of 3 patient trolley	Provided ☐	Not Provided ☐
viii.	Patient lifting devices	Provided ☐	Not Provided ☐
ix.	Fridge / Freezer to produce ice	Provided ☐	Not Provided ☐
x.	Minimum of 4 bedded Recovery Room / High Dependency Unit, equipped with oxygen supply and monitoring devices.	Provided ☐	Not Provided ☐
xi.	Designated Scrub, changing and storage areas	Provided ☐	Not Provided ☐
xii.	Reception and rest areas	Provided ☐	Not Provided ☐
xiii.	Minimum of 2 Anesthetic rooms	Provided ☐	Not Provided ☐
xiv	Full Isolation facilities with entry control Positve pressure Hepa filtered airconditioning Parents area with both way	Provided ☐	Not Provided ☐

3.) Pharmacy:

i.	Round the clock dedicated staff (with number) to respond to needs of transplant patients specially immunosuppression, antibiotics and other drugs.	Provided ☐	Not Provided ☐

4.) Intensive Care Unit:

i.	Minimum 4 ICU beds	Provided ☐	Not Provided ☐
ii.	Monitoring and ventilation	Provided ☐	Not Provided ☐
iii.	Proper oxygen supply	Provided ☐	Not Provided ☐

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5) Blood Bank:

Hospital should have blood bank facilities or proper arrangements with recognized blood bank with proper storage facility.

i.	Typing and cross matching tests Antibody screening and typing	Yes ☐	No ☐
ii.	Blood storage facility	Yes ☐	No ☐
iii.	Cell separator	Yes ☐	No ☐
iv.	Ability to provide blood components	Yes ☐	No ☐

6) Record Keeping: According to Proforma provided

i.	List of transplants performed in the last 12 months	Provided ☐	Not Provided ☐
ii.	Record of morbidity mortality and audit meetings	Provided ☐	Not Provided ☐
iii	**Physiotherapy services:**	Provided ☐	Not Provided ☐

7) Library and other Resources:

i.	Computers	Provided ☐	Not Provided ☐
ii.	Internet Access	Provided ☐	Not Provided ☐
iii.	24 hours availability of communication system, with power backup.	Provided ☐	Not Provided ☐
iv.	Public telephone systems	Provided ☐	Not Provided ☐
v.	Fax Machine	Provided ☐	Not Provided ☐
vi.	Photo-imaging machine	Provided ☐	Not Provided ☐

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