The Punjab Transplantation of Human Organ and Tissue, Rules

(To be filled by either parent of dead child under 18 year)

I Mr. / Mrs. / Ms. ……son of, wife of ……CNIC No…….. resident of ……..hereby authorized removal of the organ namely Renal / Liver/ Cornea/ Heart / Pancreas / Lungs etc. for therapeutic purposes from the dead boy of my son / daughter, Mr/ Mrs ……aged ……..whose brain stem death has been duly certified in accordance with the law.

Signature……

Name ……..

Place……..

Dated……

Witnesses

(1) Mr. / Mrs. / Ms. ……s/o, d/o, w/o, Mr…….....

CNIC No……aged……resident of……....

……..

Tel…….

Signature…….

(2) Mr. / Mrs. / Ms. ……..s/o, d/o, w/o, Mr…….....

CNIC No……aged……resident of ……

……..

Tel……..as a close blood relative to the donor as Father/ Mother/ Brother/ Sister / Son/ Daughter/ Husband / Wife.

Date……..

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(To be filled by the Brain Death Committee)

We, the following member of Brain Death committee examination, hereby certify that Mr./Mrs./Ms……s/o,d/o,w/o,…… aged……..CNIC NO.……resident of ……is dead on account of permanent an irreversible cessation of all function of brain stem. The test carried out by us and the findings therein are recorded in the brain stem death certificate annexed hereto.

Name: ……..

Designation:…….

Date…….. Signature……..

Name: ……..

Designation:…….

Date…….. Signature……..

Name: ……..

Designation:…….

Date…….. Signature……..

Name: ……..

Designation:…….

Date…….. Signature……..

Brain Death Certification

To be filled by
Physician/Pediatrician/ICU Specialist/Neuro Physician/Neuro Surgeon/Anesthesiologist/Medical Intensivist

Patient's Information

Patient's Name: _____ Father's Name: _____

Age: _____ Contact No: _____

Address: _____

CNIC No: _____ Hospital Reg No:_____

Section 1 - Prerequisite

Use of CNS depressant drugs in last 24 hours	Yes ☐	No ☐
Hypothermia (Systolic BP < 90mm)	Yes ☐	No ☐
Hypotension	Yes ☐	No ☐
Alcohol Intoxication	Yes ☐	No ☐
Neuromuscular Blocking Agents	Yes ☐	No ☐
Severe Electrolyte + Acid base imbalance	Yes ☐	No ☐

If all are **NO**

If any or all are **Yes**

Section 2 - Evidence of Absence of Brainstem Reflexes

Non Responsive mid dilated pupil 4-9 mm	No ☐	Yes ☐
Absence of Dolls Eye Movement	No ☐	Yes ☐
Absence of Eye Movement to Caloric Testing	No ☐	Yes ☐
Absence of Corneal Reflex	No ☐	Yes ☐
Absence of Facial Movement / Evincing to a Noxious Movement	No ☐	Yes ☐
Absence of Gag Reflex	No ☐	Yes ☐
Absence of Cough Reflex	No ☐	Yes ☐

If all are **Yes**

If any or all are **No**

Section 3 – Ancillary Test [Optional]

Cerebral Angiography	Yes ☐	No ☐	Not required ☐
Nuclear Scan	Yes ☐	No ☐	Not required ☐
Transcranial Doppler	Yes ☐	No ☐	Not required ☐

1st Declaration (Date: _____/_____/_____Time :_____)

Patient has got **Irreversible Coma,** need 2nd examination after six plus hours.

Signature	PMDC No.	Designation
Signature	PMDC No.	Designation

Note:

It must be signed by any of two of the following:
Physician/Pediatrician/ICU Specialist/Neuro Physician/Neuro Surgeon/Anesthesiologist/Medical Intensivist

Section 4 – 2nd Examination (after 6+ hours)

Date: _____/_____/_____ Time :_____

Section 5 - Evidence of Absence of Brainstem Reflexes

Non Responsive mid dilated pupil 4-9 mm	No ☐	Yes ☐
Absence of Dolls Eye Movement	No ☐	Yes ☐
Absence of Eye Movement to Caloric Testing	No ☐	Yes ☐
Absence of Corneal Reflex	No ☐	Yes ☐
Absence of Facial Movement / Evincing to a Noxious Movement	No ☐	Yes ☐
Absence of Gag Reflex	No ☐	Yes ☐
Absence of Cough Reflex	No ☐	Yes ☐

If all are **Yes**

If any or all are **No**

Section 6 – Apnea test

Absence of Respiratory Drive during Apnea Test No ☐ Yes ☐

If **Yes**

If **No**

2nd Declaration (Date: _____/_____/_____Time :_____)

Patient is declared to be **Braindead**

Signature	PMDC No.	Designation
Signature	PMDC No.	Designation

Note:

It must be signed by any of two of the following:
Physician/Pediatrician/ICU Specialist/Neuro Physician/Neuro Surgeon/Anesthesiologist/Medical Intensivist