

# Cardiac Valves 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 Cardiac Valves Transplantation.

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

Comments (if any): \_\_\_\_\_  
 \_\_\_\_\_

RECOMENDED	NOT RECOMMENDED	RECOMMENDED WITH MINOR CHANGES	RE-VISIT
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\*\*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 CARDIAC 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.	Evaluation committee – financial support, and initial screening			Yes No <input type="checkbox"/> <input type="checkbox"/>
2.	Pre- procedure care/nutrition/ psychotherapy			Yes No <input type="checkbox"/> <input type="checkbox"/>
3.	Procedure protocols			Yes No <input type="checkbox"/> <input type="checkbox"/>
4.	Post-procedure SOPs			Yes No <input type="checkbox"/> <input type="checkbox"/>
5.	Isolation room SOPs			Yes No <input type="checkbox"/> <input type="checkbox"/>
6.	infection control SOPs for area/surfaces/space/utilities			Yes No <input type="checkbox"/> <input type="checkbox"/>
7.	Mishap reporting SOP			Yes No <input type="checkbox"/> <input type="checkbox"/>
8.	Processes supervision SOPs			Yes No <input type="checkbox"/> <input type="checkbox"/>
9.	Certification from 3 <sup>rd</sup> party clearance ( Health Care commission / PHOTA)			Yes No <input type="checkbox"/> <input type="checkbox"/>
10.	Does the hospital administrator know that he is personally responsible for implementation of protocols and procedures			Yes No <input type="checkbox"/> <input type="checkbox"/>

**(B) MANPOWER REQUIREMENTS:****1) Lead Cardiac Transplant Surgeon**

Name	Medical Qualification	Permanent Employee	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Particulars and evidence of Lead Transplant Surgeon-1 provided as detailed below:**

Name  Date of Birth

Qualification: FRCS/FRCP, FCPS, MS/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<br><input type="checkbox"/>              | No<br><input type="checkbox"/>                   |
|      |  | <i>Enclosed</i>                              | <i>Not enclosed</i>                              |
| ii.  | Attested copy of specialist qualifications registered with PMDC          | <input type="checkbox"/>                     | <input type="checkbox"/>                         |
| iii. | Originals certificates required in serial No. i & ii have been Examined. | Yes<br><input type="checkbox"/>              | No<br><input type="checkbox"/>                   |
| iv.  | Original experience certificate from competent authority                 | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |

**Particulars and evidence of Cardiac Transplant Surgeon-2 provided as detailed below:**

Name	Medical Qualification	Permanent Employee	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Name  Date of Birth

Qualification: FRCS/FRCP, FCPS, MS/MD, Diplomat American Board or equivalent

CNIC  PMDC No.

Signature of Commissioner's Representative \_\_\_\_\_

Cell No  E-Mail

Residential Address

Official Address

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

**2) Cardiologist**

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

**Particulars and evidence of Cardiologist provided as detailed below:**

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

**Signature of Commissioner's Representative** \_\_\_\_\_

**3) General Physicians**

No. of Consultants / Specialists:

(Please Tick ✓ the check box)

 1  2  3Yes  No **Particulars and evidence of Consultants / Specialists provided as detailed below:**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 appropriately with PMDC (valid certificate enclosed)       | Yes <input type="checkbox"/>              | No <input type="checkbox"/>                   |
|      |   | <i>Enclosed</i>                           | <i>Not Enclosed</i>                           |
| ii.  | Attested copy of specialist qualifications registered with PMDC       | <input type="checkbox"/>                  | <input type="checkbox"/>                      |
|      |   | Yes <input type="checkbox"/>              | No <input type="checkbox"/>                   |
| iii. | Originals certificates required in Sr. No. i & ii have been examined. | <input type="checkbox"/>                  | <input type="checkbox"/>                      |
| iv.  | Original experience certificate from competent authority              | <i>Submitted</i> <input type="checkbox"/> | <i>Not Submitted</i> <input type="checkbox"/> |

**4) Anaesthetists**

No. of Consultants / Specialists:

(Please Tick ✓ the check box)

 1  2  3Yes  No **Particulars and evidence of Anaesthetist provided as detailed below:**Name  Date of Birth Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent  

Signature of Commissioner's Representative \_\_\_\_\_

CNIC

PMDC No.

Cell No.

E-Mail

Residential Address

Official Address

i. Registered appropriately with PMDC (valid certificate enclosed)

Yes

No

*Enclosed**Not Enclosed*

ii. Attested copy of specialist qualifications registered with PMDC

Yes

No

iii. Originals certificates required in Sr. No. i &amp; ii have been examined.

iv. Original experience certificate from competent authority

*Submitted**Not Submitted***5) Radiologists**

No. of Consultants / Specialists:

(Please Tick ✓ the check box)

 1  2  3

Yes

No

**Particulars and evidence of Radiologist provided as detailed below:**

Name

Date of Birth

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

CNIC

PMDC No.

Cell No.

E-Mail

Residential Address

Official Address

i. Registered appropriately with PMDC (valid certificate enclosed)

Yes

No

*Enclosed**Not Enclosed*

ii. Attested copy of specialist qualifications registered with PMDC

Yes

No

iii. Originals certificates required in Sr. No. i &amp; ii have been examined.

iv. Original experience certificate from competent authority

*Submitted**Not Submitted***6) Pathologists:**

Signature of Commissioner's Representative \_\_\_\_\_

No. of Consultants / Specialists:

(Please Tick ✓ the check box)

 1  2  3Yes  No **Particulars and evidence of Pathologist provided as detailed below:**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 appropriately with PMDC (valid certificate enclosed)       | Yes <input type="checkbox"/>              | No <input type="checkbox"/>                   |
|      |   | <i>Enclosed</i>                           | <i>Not Enclosed</i>                           |
| ii.  | Attested copy of specialist qualifications registered with PMDC       | <input type="checkbox"/>                  | <input type="checkbox"/>                      |
| iii. | Originals certificates required in Sr. No. i & ii have been examined. | Yes <input type="checkbox"/>              | No <input type="checkbox"/>                   |
| iv.  | Original experience certificate from competent authority              | <i>Submitted</i> <input type="checkbox"/> | <i>Not Submitted</i> <input type="checkbox"/> |

**7) Pharmacist:**

No. of Pharmacists:

(Please Tick ✓ the check box)

 1  2  3Yes  No **Particulars and evidence of 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 

Signature of Commissioner's Representative \_\_\_\_\_



- |      |   |  |  |
|------|---|--|--|
| i.   | Registered appropriately with Pharmacy Council(valid certificate enclosed)  | <input type="checkbox"/>                     | <input type="checkbox"/>                         |
|      |   | <i>Enclosed</i>                              | <i>Not Enclosed</i>                              |
| ii.  | Attested copy of specialist qualification registered with Pharmacy Council. | <input type="checkbox"/>                     | <input type="checkbox"/>                         |
| iii. | Originals certificates required in Sr. No. i & ii have been examined.       | Yes<br><input type="checkbox"/>              | No<br><input type="checkbox"/>                   |
| iv.  | Original experience certificate from competent authority                    | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |

**8) Transplant Coordinators:**(Please Tick  the check box)

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**Particulars and evidence of Transplant Coordinator provided as detailed below:**Name  Date of Birth Qualification: MBBS, MSc or equivalentent CNIC  PMDC No. Cell No.  E-Mail Residential Address Official Address 

- |     |  |  |  |
|-----|--|--|--|
| i.  | Registered appropriately with PMDC in case of medical practitioner                               | Yes<br><input type="checkbox"/>              | No<br><input type="checkbox"/>                   |
| ii. | Evidence of experience / courses to support essential standards requirement and job description. | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |

**9) Nursing Staff:**

Signature of Commissioner's Representative \_\_\_\_\_

**11 a) Nursing Staff-1:**

Name	Qualification	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

**Particulars and evidence of all nursing staff-1 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  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| ii.  | Attested copy of original Nursing and matriculation qualification.                                      | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iii. | Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively. | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iv.  | Experience / Training certificate in handling patients on dialysis.                                     | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |
| v.   | Transplant operation Theatre experience / Training Certificate. Wherever applicable.                    | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |
| vi.  | ICU Training certificate. Wherever applicable.  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |

**11 b) Nursing Staff-2:**

Name	Qualification	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

**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  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| ii.  | Attested copy of original Nursing and matriculation qualification.                                      | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iii. | Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively. | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iv.  | Experience / Training certificate in handling patients on dialysis.                                     | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |
| v.   | Transplant operation Theatre experience / Training Certificate. Wherever applicable.                    | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |
| vi.  | ICU Training certificate. Wherever applicable.  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |

**11 c) Nursing Staff-3 / ICU Sister:**

Name	Qualification	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

**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  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| ii.  | Attested copy of original Nursing and matriculation qualification.                                      | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iii. | Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively. | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iv.  | Experience / Training certificate in handling patients on dialysis.                                     | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |
| v.   | Transplant operation Theatre experience / Training Certificate. Wherever applicable.                    | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |
| vi.  | ICU Training certificate. Wherever applicable.  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not Submitted</i><br><input type="checkbox"/> |

**10) Data Entry / Computer Operator:**

**Particulars and evidence of Data Entry / Computer Operator provided as detailed below:** Yes  No

Name  Date of Birth

CNIC  E-Mail

Cell No.

Residential Address

Official Address

- |      |  |  |  |
|------|--|--|--|
| i.   | Attested copy of Graduate qualification        | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| ii.  | Attested copy of Microsoft office certificate. | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iii. | Attested copy of Experience certificate        | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |

**11) Perfusionists:**

**13 a) Perfusion Technician-1**

Signature of Commissioner's Representative \_\_\_\_\_

Name	Qualification	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

**Particulars and evidence of Perfusion 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 perfusion           | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| ii. Attested copy of experience certificate in handling patients on perfusion | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iii. Attested copy of Experience certificate                                  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |

**13 b) Perfusion Technician-2**

Name	Qualification	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

**Particulars and evidence of Perfusion Technician-2 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 perfusion           | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| ii. Attested copy of experience certificate in handling patients on perfusion | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |
| iii. Attested copy of Experience certificate                                  | <i>Submitted</i><br><input type="checkbox"/> | <i>Not submitted</i><br><input type="checkbox"/> |

**B) EQUIPMENT REQUIREMENT:****1 Laboratory Service:**

	<b>Availability</b> (Certificate to be provided by the hospital)		<b>Functionality</b> (Certificate to be provided by the hospital)	
	Present	Not Present	Functionality	Not Functionality
Haematology Cell Counter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemistry Analyser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electrolyte Analyser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Gas Analyser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Bank Fridges 4.C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ELISA Plate reader and washer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissection microscope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tissue processor, manual or preferably automated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tissue embedding center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microtome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold Centrifuge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Micro Centrifuge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microscope Fluorescent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microscopes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roller Mixers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automatic pipettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2A) Radiology Department (Thallium Study)**

	<b>Availability</b> (Certificate to be provided by the hospital)		<b>Functionality</b> (Certificate to be provided by the hospital)	
	Present	Not Present	Functioning	Not Functioning
X-ray machine / Digital X-ray / Mobile X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doppler ultrasound machine with needle guide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2B) Cardiac Catheterization & Angiography:**

*Disposables / Materials:*

	Provided	Not Provided
Contrast material for IVP	<input type="checkbox"/>	<input type="checkbox"/>
Biopsy needle and gun	<input type="checkbox"/>	<input type="checkbox"/>
Sterilizing kits with gauze, pyodine, sterile gloves opsite, syringes	<input type="checkbox"/>	<input type="checkbox"/>
PCN / drainage packs.	<input type="checkbox"/>	<input type="checkbox"/>

**2C) Nuclear Radiology:**

Gamma Camera

**3) Anesthesia Department:**

	<b>Availability</b> (Certificate to be provided by the hospital)		<b>Functionality</b> (Certificate to be provided by the hospital)	
	Present	Not Present	Functioning	Not Functioning
Anesthesia machine and its affiliated functions (preferably with computerized ventilator)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Commissioner's Representative \_\_\_\_\_

Monitoring devices:	Present	Not present	Functioning	Not Functioning
ECCG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse oximetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
End Tidal CO <sub>2</sub>				
Non-invasive BP monitor				
Invasive BP monitor				
Temperature monitor (surface and Core)				

Central venous pressure monitor				
Suction Machine	Present <input type="checkbox"/>	Not present <input type="checkbox"/>	Functioning <input type="checkbox"/>	Not Functioning <input type="checkbox"/>

Warming Devices:	Present	Not present	Functioning	Not Functioning
Fluid warming cabinet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion warmer				
Warming mattress				
Warming Blanket				
Warm air bler				

**Disposables / Materials:**

Airway management gadgets (laryngoscope, Bougie, Stylettes, Endotracheal tubes, Laryngeal masks, Fiberoptic laryngo scope etc)	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Reserve gas cylinders (O <sub>2</sub> , N <sub>2</sub> O, Air)	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>

Infusion pumps	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
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Syringe pumps	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
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Nerve stimulators	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
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CVP catheters (double and triple lumen)	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
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**4) Pharmacy Department:**

The pharmacy must provide the following minimum requirements.

**Disposables/ Materials:**

IV anesthetic agents	Provided	Not Provided
Thiopentone	<input type="checkbox"/>	<input type="checkbox"/>
Propofol		
Narcotics	Provided	Not Provided
	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Commissioner's Representative \_\_\_\_\_



Non depolarizer muscle relaxants	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Inotrops	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Dopamine	<input type="checkbox"/>	<input type="checkbox"/>
Dobutamine	<input type="checkbox"/>	<input type="checkbox"/>
Phenyl ephrine	<input type="checkbox"/>	<input type="checkbox"/>
Adrenaline	<input type="checkbox"/>	<input type="checkbox"/>
Nor epinephrine	<input type="checkbox"/>	<input type="checkbox"/>
Beta Blockers	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Inj. Labetalol	<input type="checkbox"/>	<input type="checkbox"/>
Inderal)	<input type="checkbox"/>	<input type="checkbox"/>
Vasodilators	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
GTN	<input type="checkbox"/>	<input type="checkbox"/>
Hydralazine	<input type="checkbox"/>	<input type="checkbox"/>
Nitro Prusside	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetic	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Bupivaccin	<input type="checkbox"/>	<input type="checkbox"/>
Xylocaine	<input type="checkbox"/>	<input type="checkbox"/>
Naloxone	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Calcium chloride	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Mg SO4	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Immunosuppressive drugs.	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Urine bags, Catheters	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Hemodialysis and peritoneal dialysis, Catheters and solution	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Anti-biotic, Anti-viral and Anti-fungal agents	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Endotracheal tubes, Laryngeal masks, Central Venous Catheters	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Dressings	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
<b>5) Intensive Care Unit:</b>		
At least four bedded facility for 48 hours intensive care	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Maneuverable bed equipped with facility for cardiac monitoring, invasive monitoring, NIBP and Oximetry.	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Stand by ventilator	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>

Signature of Commissioner's Representative \_\_\_\_\_

Basic resuscitation trolley  
 Complete in every respect as defined  
 in Annexure.....

Provided

Not Provided

**6) Operation Theatre Department: Minimum Surgical Instrument required for cardiac transplantation.**

	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
<b>i. Basic General Set for Operation Theatre</b>	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
<b>ii. cardiovascular thoracotomy sternotomy set</b>	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
Reynolds Scissors CVD 175 mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Arteriotomy scissors Debakey CVD 175mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Durotip Scissors 220mm CVD	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
NonTraumatic Vessel Forceps 150mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Durogrip forceps 20 cm Slender Type	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Durogrip Dissecting Forceps 180mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Baby Mixture Forceps 140 mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Jacobson Needle Holder W. Catch 185mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Durogrip Debakey Needle holder 230mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Durogrip Debakey Needle holder 250mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Durogrip Needle Holder Ryder 155mm Delic	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
ATR Neonatal Miniature Forceps Small	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
ATR Neonatal Miniature Forceps Medium	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
ATR Neonatal Miniature Forceps Large	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
ATR Neonatal Miniature Forceps Clamp Curved	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Non Traum Forceps cooley 90 Degree Small 165mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
De Bakey Bulldog Clamp Curved 50mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>

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A TR Bulldog Clamp De Bakey CVD	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
A TR Bulldog Clamp De Bakey CVD 23/78mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
A TR Bulldog Clamp De Bakey CVD 31/86mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
A TR Bulldog Clamp De Bakey CVD 42/97mm	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Stanskey Vena-Cava Clamp Large	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Stanskey Vena-Cava Clamp Medium	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Stanskey Vena-Cava Clamp Large	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Potts Scissors on Angle	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Watson-Cheyon probe and Dissector	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Omnai- Track Self Retaining Retractor (for vascular procedure)	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
Sterile Ice making Machine	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>
De Bakey Bulldog Clamp (Cross Action)	Present <input type="checkbox"/>	Not Present <input type="checkbox"/>

iii. For other requirements of operation theatre departments. Please see the section C of specialized services and facilities.

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**C) SPECIALIZED SERVICES AND FACILITIES:**

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

**1) Laboratory Service:**

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

i.	<b>HEMATOLOGY:</b>	Yes	No
	Routine Blood Counts / Peripheral films	<input type="checkbox"/>	<input type="checkbox"/>
	Screening for sick cell / haemoglobinopathy patients/ Malaria Parasites	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ii.	<b>Microbiology:</b>	Yes	No
	Culture and Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
iii.	<b>Chemical pathology:</b>	Yes	No
	Biochemical Investigations	<input type="checkbox"/>	<input type="checkbox"/>
	Organ Function Tests	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	24 hours urinary analysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iv.	<b>Histopathology:</b>	Provided	Not Provided
	Routine processing and reporting of biopsy	<input type="checkbox"/>	<input type="checkbox"/>
	Cytology specimens process and reporting	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
v.	<b>Immunology:</b>	Provided	Not Provided
	Tissue typing	<input type="checkbox"/>	<input type="checkbox"/>
	Immunosuppressive drug monitoring	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
	Molecular diagnostic facilities	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
	24 hours availability of laboratory	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**2) Operation Theatre And Anesthesia Department:**

i.	Minimum two operating theatres	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
ii.	Separate theatre available for transplant procedures only	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
iii.	State of sterilization:	Provided	Not Provided
	Autoclave	<input type="checkbox"/>	<input type="checkbox"/>
	Operating instructions	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
	Maintenance certificate	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
	Quality control on efficacy of sterilization	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>

iv. Ventricular Assist Device	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
v. SOPs of Operation Theatre	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
vi. Theatre personnel: Minimum of 6 trained staff Nurses Minimum of 4 Operation Theatre Assistants	Provided <input type="checkbox"/> Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/> Not Provided <input type="checkbox"/>
Minimum of 6 ancillary staff	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
vii. Minimum of 2 electronically operated operation tables with high quality light devices	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
viii. Minimum of 3 patient trolley	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
ix. Patient lifting devices	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
x. Fridge / Freezer to produce ice	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
xi. Minimum of 4 bedded Recovery Room / High Dependency Unit, equipped with oxygen supply and monitoring devices.	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
xii. Designated Scrub, changing and storage areas	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
xiii. Reception and rest areas	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
xiv. Minimum of 2 Anaesthetic rooms	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>

**3.) Pharmacy:**

i. Round the clock dedicated staff (with number) to respond to needs of transplant patients specially immunosuppression, antibiotics and other drugs.	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
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**4) Dialysis Facilities:**

i. Availability of portable Dialysis Machine for ICU	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
ii. Minimum four Dialysis Machines in hospital	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
iii. 2 of 4 dialysis Machines reserved for hepatitis positive patients.	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
iv. Water purification system (e.g. Reverse Osmosis etc)	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
v. Monitoring facilities	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>
vi. Disposable and dialysis solutions	Provided <input type="checkbox"/>	Not Provided <input type="checkbox"/>

**6) 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     | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |
| ii.  | Blood storage facility              | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |
| iii. | Cell separator                      | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |
| iv.  | Ability to provide blood components | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |

**7) Record Keeping: According to Proforma provided**

- |      |   |                                      |  |
|------|---|--------------------------------------|--|
| i.   | Attach List of operations performed in the last 12 months | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| ii.  | Attach List of dialysis performed in the last 12 months   | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| iii. | Attach Record of morbidity mortality and audit meetings   | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |

**8) Library and other Resources:**

- |      |  |                                      |  |
|------|--|--------------------------------------|--|
| i.   | Computers  | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| ii.  | Internet Access  | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| iii. | 24 hours availability of communication system, with power backup.          | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| iv.  | Public telephone systems   | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| v.   | Fax Machine  | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| vi.  | Photo-imaging machine  | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |
| vii. | Advisory and committee room with 8-10 chairs (For patient related meeting) | Provided<br><input type="checkbox"/> | Not Provided<br><input type="checkbox"/> |

### Cardiac Operation Theatre Instrument Requirements

Sr. No.	Instruments	Qty.	Functional / Not Functional	
1.	Spider (Large)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
2.	Right Angle	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
3.	Suction Nozzle (Large)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
4.	Suction Nozzle (Small)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
5.	Wire Cutter	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
6.	Twister	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
7.	Mastoid Retractor	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
8.	Sponge Holder	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
9.	Leg Applier (Large)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
10.	Leg Applier (Small)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
11.	Needle Holder (Large)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
12.	Needle Holder (Small)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
13.	Needle holder 4/0	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
14.	Needle Holder (Vicral)	03	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
15.	Snare Hook	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
16.	BP Handle (7#)	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
17.	BP Handle (4#)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
18.	BP Handle (3#)	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
19.	Nerve Hook	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
20.	Watson Chain	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
21.	Roberts	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
22.	Oshonsy	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
23.	Cross Clamp	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
24.	Sam's	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
25.	Lung Holder	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
26.	Brocks	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
27.	Side Biting Clamp	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
28.	Alice Forceps	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
29.	Toulal Clip	06	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
30.	Large Debrkey	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
31.	Medium Debrkey	03	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
32.	Fine Debrkey	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
33.	Small Debrkey	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
34.	Plain Forceps	03	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
35.	Dissecting Scissor	03	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
36.	Suture Cutting	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
37.	Heavy Scissor	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
38.	Artery Forceps (Large)	15	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
39.	Artery Forceps (Small)	15	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
40.	Artery Forceps (Straight)	04	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
41.	Wire Holder	16	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
42.	Tubing Clamp	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
43.	Small Bowl	04	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
44.	Kidney Tray (Large)	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
45.	Kidney Tray (Small)	02	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional

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46.	Probe 1.5	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
47.	Probe 1	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
48.	Reverse Scissors	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
49.	Right Angle Scissor	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
50.	Forward Scissor	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
51.	Jero	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
52.	Irus	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
53.	Needle Holder 7/0	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
54.	Needle Holder 6/013	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional
55.	Fine Hook	01	<input type="checkbox"/> Functional	<input type="checkbox"/> Not Functional

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