Corneal Evaluation R-Form

(2018)

FOR PRIVATE EYE CLINIC / EYE CENTRE

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.

Signature of Commissioner's Representative_____

FOR PRIVATE EYE CLINIC / EYE CENTRE

1. The Private Eye clinic / Eye Centre will be considered as that institution in which day care Eye Surgery is performed & patients are not admitted for overnight stay.

Name of Eye Clinic/ Eye Centre: _____

Date of visit: _____ Purpose of Visit: Registration for Corneal Transplantation

Sr#	Items checked	Yes	No
1.	**Accreditation licensing 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***		
	Above five mentioned list of items mandatory to proceed further. If any one of them is mentioned NO. Do not Proceed further.		
6.	Record / one year list of donors recipient with contact numbers		
7.	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)	
6.	Any other 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_____

A) HR REQUIREMENT:

1) Ophthalmologist / Eye Surgeon:

Name	Medical Qualification	Permanent Employee
		Yes ☐ No ☐

Particulars and evidence of Transplant Surgeon / Ophthalmologist 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 ☐	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* ☐

2) Anaesthetist / MOU with Anaesthetist / Under Supervision of Surgeon:

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

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Anaesthetist provided as detailed below:

Name ☐ Date of Birth ☐

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

CNIC ☐ PMDC No. ☐

Signature of Commissioner's Representative_____

Cell No. | E-Mail

Residential Address

Official Address

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

3) Transplant Coordinator (Medical Officer / Ophthalmic Technologist / Optometrist / Record Keeper).

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of Transplant Coordinator provided as detailed below:

Name | Date of Birth

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

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

Signature of Commissioner's Representative_____

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

4) Nursing Staff / OT Assistant:

Name	Qualification	Yes	No
		☐	☐

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

Name _____ Date of Birth _____

CNIC _____ Reg. No. _____

Cell No. _____ E-Mail _____

Residential Address _____

Official Address _____

		Submitted	*Not submitted*
i.	valid certificate of registration with the Nursing Council, if staff Nurse.	☐	☐
ii.	Attested copy of original matriculation qualification.	☐	☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	☐	☐
iv.	Experience / Training certificate.	*Submitted* ☐	*Not Submitted* ☐

B) DIAGNOSTIC FACILITY STAFF REQUIREMENT:

1) Ophthalmic Technologist:

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of Ophthalmic Technologist provided as detailed below:

Name _____ Date of Birth _____

Signature of Commissioner's Representative_____

CNIC | E-Mail

Cell No.

Residential Address

Official Address

Submitted *Not submitted*

i. Attested copy undergraduate degree in Ophthalmic Technology ☐ ☐

C) Operation Theatre: 110 square feet – 150 square feet (10 ft X 11 ft - 10 ft X 15 ft)

Yes ☐ No ☐

D) Scrub Area: 50 ft - 60 square feet (5 ft X 10 ft - 6 ft X 10 ft)

Yes ☐ No ☐

E) Recovery Room: 125 square feet (10 ft X 12.5 ft) X 2

Yes ☐ No ☐

F) Operation Theater Equipment

- Operating microscope Yes ☐ No ☐
- Microsurgical instruments for corneal graft
  - Cataract sets Yes ☐ No ☐
  - Trephines of different diameter Yes ☐ No ☐
  - Curved corneal scissors Yes ☐ No ☐
  - General anesthesia machine(Optional) Yes ☐ No ☐
  - Emergency tray Yes ☐ No ☐
- Sterilization equipment
  - Sterilization room 8 ft X 4 ft Yes ☐ No ☐
  - Autoclave Yes ☐ No ☐
  - Hot air oven Yes ☐ No ☐

G) Eye Examination Room 100 sq ft – 120 sq ft (10 ft X 10 ft –10 ft X 12 ft)

Signature of Commissioner's Representative_____

	Yes ☐	No ☐
• Slit lamp	Yes ☐	No ☐
• Applanation tonometer	Yes ☐	No ☐
• Autorefractometer	Yes ☐	No ☐
• Visual box	Yes ☐	No ☐
• Indirect ophthalmoscope	Yes ☐	No ☐
• Retinoscope	Yes ☐	No ☐
• Trial lens	Yes ☐	No ☐
• Keratometer	Yes ☐	No ☐
H) Waiting area Plus reception area for O.T	Yes ☐	No ☐
Waiting area plus reception for O.P.D	Yes ☐	No ☐

Signature of Commissioner's Representative_____