PHOTA
Punjab Human Organ Transplant Authority

Corneal Evaluation R-Form

(2018)

FOR PRIVATE / PUBLIC HOSPITAL

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 / PUBLIC HOSPITAL

1. The Private / Public Hospital will be considered as that institution which has indoor facility for admission of the Patients.

Name of Hospital: _____

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 Ophthalmologist / Transplant Surgeon 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:

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 ☐

Signature of Commissioner's Representative_____

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* ☐

3) General Physician:

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

☐ 1 ☐ 2 ☐ 3

Yes ☐ 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

Signature of Commissioner's Representative_____

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

4) Pathologist (Optional) / MOU with a pathology Lab:

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

☐ 1 ☐ 2 ☐ 3

Yes ☐ 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 _____

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

Signature of Commissioner's Representative_____

5) Pharmacist (In case Pharmacy is Operational):

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

☐ 1 ☐ 2 ☐ 3

Yes ☐ 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 _____

i. Registered with Pharmacy Council(valid certificate enclosed) — Yes ☐ No ☐

ii. Attested copy of specialist qualification registered with Pharmacy Council. — *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) Transplant Coordinator (Medical Officer / Ophthalmic Technologist / Optometrist)

Name	**Medical Qualification**	Yes	No
		☐	☐

Particulars and evidence of Transplant Coordinator provided as detailed below:

Name _____ Date of Birth _____

Signature of Commissioner's Representative_____

Qualification: MBBS, BSc, MSc or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered with PMDC in case of medical practitioner	☐	☐
		Submitted	*Not submitted*
ii.	Evidence of experience / courses to support essential standards requirement and job description.	☐	☐

7) 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 in case of Nursing staff.	☐	☐
		Submitted	*Not submitted*
ii.	Attested copy of original matriculation qualification.	☐	☐
		Submitted	*Not submitted*
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	☐	☐
		Submitted	*Not Submitted*
iv.	Experience / Training certificate	☐	☐

Signature of Commissioner's Representative_____

8) Anaesthesia Assistant:

Name	Medical Qualification	Yes	No
		☐	☐

Particulars and evidence of Anaesthesia Assistant provided as detailed below:

Name _____ Date of Birth _____

CNIC _____ E-Mail _____

Cell No. _____

Residential Address _____

Official Address _____

		Submitted	*Not submitted*
i.	Attested copy of Anaesthesia Technician Diploma	☐	☐
ii.	Attested copy of Experience certificate	☐	☐

B) DIAGNOSTIC FACILITY STAFF REQUIREMENT:

1) Ophthalmic Technologist / Optometrist / Assistant :

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of Ophthalmic Technologist/Optometrist/Assistant provided as detailed below:

Name _____ Date of Birth _____

CNIC _____ E-Mail _____

Cell No. _____

Signature of Commissioner's Representative_____

Residential Address	
Official Address	

	Submitted	*Not submitted*
Attested copy undergraduate degree in Ophthalmic Technology/optometry/Assistant	☐	☐

C) EYE TISSUE BANK STAFF REQUIREMENT (in case of an Eye Bank):

1) Eye Bank Manager:

Name	**Qualification**	Yes	No
		☐	☐

Particulars and evidence of Eye Bank Manager provided as detailed below:

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

	Submitted	*Not submitted*
i. Attested copy undergraduate degree in Social Sciences	☐	☐

2) Eye Bank Assistant:

Name	**Medical Qualification**	Yes	No
		☐	☐

Particulars and evidence of Eye Bank Ophthalmic Assistant 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 undergraduate degree in Ophthalmic Technology	☐	☐

D) OTHER STAFF:

1) Data Entry / Computer Operator / Record Keeper:

Name	**Qualification**	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

Official Address

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

Submitted *Not submitted*

Signature of Commissioner's Representative_____

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

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

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

H) Operation Theater Equipment

- Operating microscope with a teaching aid 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 Yes ☐ No ☐
    - Emergency cart Yes ☐ No ☐
- Sterilization equipment
    - Sterilization room 8 ft X 6 ft Yes ☐ No ☐
    - Autoclave Yes ☐ No ☐
    - Hot air oven Yes ☐ No ☐

I) Laboratory facilities for basic tests (In case of Lab Facility)

Basic tests including

- CBC Yes ☐ No ☐
- Blood sugar Yes ☐ No ☐
- Lipid profile Yes ☐ No ☐
- Urine test Yes ☐ No ☐
- ESR Yes ☐ No ☐

Signature of Commissioner's Representative_____

J) OPHTHALMOLOGY DIAGNOSTIC FACILITY: 120 sq ft (12 ft X 10 ft)

Yes ☐ No ☐

- Ophthalmic ultrasound Yes ☐ No ☐

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

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 ☐

L) 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_____