DONOR FORM (I)

(Close Blood Relatives)

To be filled by recognized Transplant Surgeon/ Physician

Date: _____

PERSONAL INFORMATION:

Name_____Age_____Sex_____Weight/BMI_____

Occupation_____Address _____

CR #_____HD #_____Donor # _____

Contact #_____

ACTIVE COMPLAINT:

Complaint	Present	Absent
Nausea/Vomiting	☐	☐
Decreased Appetite	☐	☐
Body Aches	☐	☐
Generalized Weakness	☐	☐
Fever	☐	☐
Shortness of Breath	☐	☐
Chest Pain	☐	☐

Any Other _____

PAST HISTORY:

Systemic Illnesses

DM	☐	Yes	☐	No	HTN	☐ Yes	☐ No
					IHD	☐ Yes	☐ No

Nervous System / Psychiatric & behavioral disorders

Stroke	☐	Yes	☐	No	TIAs	☐ Yes	☐ No
Psychiatric Illness	☐	Yes	☐	No	Depression	☐ Yes	☐ No

Respiratory System

Asthma / COPD	☐	Yes	☐	No	Uses Inhalers	☐ Yes	☐ No
Pulmonary TB	☐	Yes	☐	No	Haemoptysis	☐ Yes	☐ No

Cardiovascular System

Chest Pain	☐	Yes	☐	No	SOB on exertion	☐ Yes	☐ No
Orthopnea	☐	Yes	☐	No	Palpitations	☐ Yes	☐ No

_____ _____

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Gastro/ Hepatic System

Jaundice	☐	Yes	☐	No	Chronic Diarrhea	☐ Yes	☐ No
Back Stool	☐	Yes	☐	No	Abdominal pain	☐ Yes	☐ No

Genitor / Urinary System

Dysuria	☐	Yes	☐	No	Frequency	☐ Yes	☐ No
Urgency	☐	Yes	☐	No	Nocturia	☐ Yes	☐ No
Hematuria	☐	Yes	☐	No	Proteinuria	☐ Yes	☐ No
Dribbling	☐	Yes	☐	No	Passage of Stones	☐ Yes	☐ No
Retention	☐	Yes	☐	No			

PAST SURGICAL HISTORY_____

_____

CURRENT MEDICATIONS_____

SUBSTANCE ABUSE:

	Yes	**No**	**Amount / Day**	**Since When?**
Cigeratte / Hukka	☐	☐	_____	_____
Tobacco / Pans	☐	☐	_____	_____
Naswar	☐	☐	_____	_____
Heroin	☐	☐	_____	_____
Marijuana	☐	☐	_____	_____
Alcohol	☐	☐	_____	_____

OBSTETRIC HISTORY:

Menstrual History _____

Amennorhea _____

If yes: ☐ Pregnant (Pregnancy Test) ☐ Menopause

No. of Children _____Modes of Deliveries_____No. of Abortions (if any)_____

Tubal Ligation _____OCPs _____

SOCIAL HISTORY:

No. of Family members living in the same house_____No. of earning members_____

Total Income _____ PKR/Month

_____ _____

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PHYSICAL EXAMINATION

Vital Signs

Pulse _____ Temperature _____ Resp. Rate _____

Blood Pressure _____

Physical Signs

	Yes	No		Yes	No
Anemia	☐	☐	Tongue	☐	☐
Cyanosis	☐	☐	Normal	☐	☐
Jaundice	☐	☐	Coated	☐	☐
Koilonychia	☐	☐	Furred	☐	☐
Clubbing	☐	☐	Fissured	☐	☐
Edema	☐	☐			
Lymph Nodes	☐	☐			
a. Cervical	☐	☐	Rash		
b. Axillary	☐	☐	Site	_____	
c. Supra-calvicular	☐	☐	Type		
d. Inguinal	☐	☐	Duration		
Enlarged Thyroid	☐	☐			
Raised JVP	☐	☐	Joint Deformities	**Yes** ☐	**No** ☐

Systemic Examination

Cardiovascular _____ Respiratory _____

Abdomen _____ Genitourinary _____

Nervous _____ Musculo-Skeletal _____

_____ _____

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INVESTIGATIONS

Blood Group _____

Hb _____ PCV _____ MCV _____ WBC _____ Platelets _____

Serum Urea _____ Serum Creatinine _____ Serum Sodium _____

Serum Potassium _____ Serum Chloride _____ Serum Bicarbonate _____

Total Bilirubin _____ Direct Bilirubin _____ ALK Phosphatase _____

ALT _____ AST _____ GGT _____

Blood Sugar (Random) _____

Serum Calcium _____

PT / APTT _____

Urine Complete Examination:

Proteins _____ Blood _____ RBC _____

WBC _____

HBsAg _____ Anti HCV _____

CMV IgG _____

HLA Tissue Typing & Cross-match result _____

_____

Mountex Test _____ TB Quantiferon Test _____

HIV Screening _____

Abdomen _____

Chest X-ray _____

ECG _____

Echocardiogram (Selective) _____

If Donor is Diabetic get the following before referring to Diabetic OPD:

☐ BS(Fasting) ☐ BS(Random) ☐ HbAIC ☐ Fasting Lipid Profile ☐ ECG ☐ ECHO

☐ Cardiac Opinion ☐ EYE Opinion ☐ Dental Opinion

Filled by DR. _____ ***Signature:*** _____ ***Date:*** _____

_____ _____

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DOCUMENTS REQUIRED FOR DONATION OF ORGAN BY CLOSE BLOOD RELATIVE

A) PATIENT:

Name:_____S/O, D/O_____

National Identity Card (CNIC) No. _____(Attach Copy)

Age (D.O.B): _____Blood Group: _____Sex: _____(Attach Report)

Referred by: _____(Attach Copy)

Tissue Typing: _____

_____

B) CLOSE BLOOD RELATIVES:

Sr. #	Relation	Name	S/O, D/O, W/O	Blood Group	Reason of Ineligibility*	CNIC #
WIFE/ HUSBAND						
FATHER						
MOTHER						
BROTHER						
SISTERS						
SONS						
DAUGHTERS						

_____ _____

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C) CLOSE BLOOD RELATIVE DONOR:

Name: _____ S/o, D/o _____

National Identity Card (CNIC) No. _____ (Attach Attested Photocopy)

Resident of: _____

Age (D.O.B): _____ Blood Group: _____ (Attached Report)

Tissue Typing: _____

Sex: _____ Referred by: _____ (Attached Copy)

Close / Non-Close / Non –Relatives: _____

Relations of Recipient:

1. Father: _____
2. Mother: _____
3. Wife / Husband: _____

EVIDENCE REQUIRED FROM CLOSE BLOOD RELATIVES

1. Affidavit duly notified by Judicial Magistrate witnessed by at least two independent witnesses to confirm close blood relationship and intent of voluntary donation as prescribed in the proforma.
2. Documentary evidence from NADRA / Director General Immigration of passports confirming residential address and particulars of parentage.
3. Documentary evidence of relationship including CNIC, Birth Certificates and marriage certificates. (as applicable)
4. Documentary evidence of identity and residence of the proposed donor in the form of CNIC or Passport or Driving License.
5. Certificate from a Psychiatrist to confirm the mental condition and ability to give free consent if desired by Evaluation Committee.
6. Results of tests for HLA-alleles, A,B and DR, performed by serology and/or DNA-PCR methods from HOTA approved Labs with ISO 15181 certification.
7. In case of dispute or doubt, the Evaluation Committee may demand Microsatellite Gene Analysis certificate to confirm relationship between donor and recipient.

_____ _____

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AUTHORIZATION STATEMENT FROM THE DONOR

I Mr/Miss/Mrs. _____ S/O, D/O being the donor, resident of _____ with CNIC NO. _____ and Cell Phone No. _____

hereby voluntarily authorize the Transplant Surgeon (Name) _____ of _____ to
(Hospital Name & Address)
remove my _____ for transplantation purposes to the
(Organ)
recipient Mr. / Miss / Mrs _____ S/o, D/o _____ resident of _____ with CNIC No. _____ and cell phone No. _____.

I hereby confirm that I am donating my organ, without any financial incentives and under no compulsion.

Name: _____

Signature: _____

CNIC: _____

_____ _____

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