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 # ___________________________ Urine Output __________________________________

Angio Access: ☐ Femoral ☐ Jugular ☐ Subclavian ☐ AVF

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

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	Bronchietasis	☐ Yes	☐ No

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Signature & Stamp of Administrator of Hospital

DONOR-I

Cardiovascular System

Chest Pain	☐ Yes	☐ No	SOB on exertion	☐ Yes	☐ No
Orthopnea	☐ Yes	☐ No	Past MI	☐ Yes	☐ No

Gastro / Hepatic System

Jaundice	☐ Yes	☐ No	Chronic Diarrhea	☐ Yes	☐ No
Back Stools	☐ 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 ____

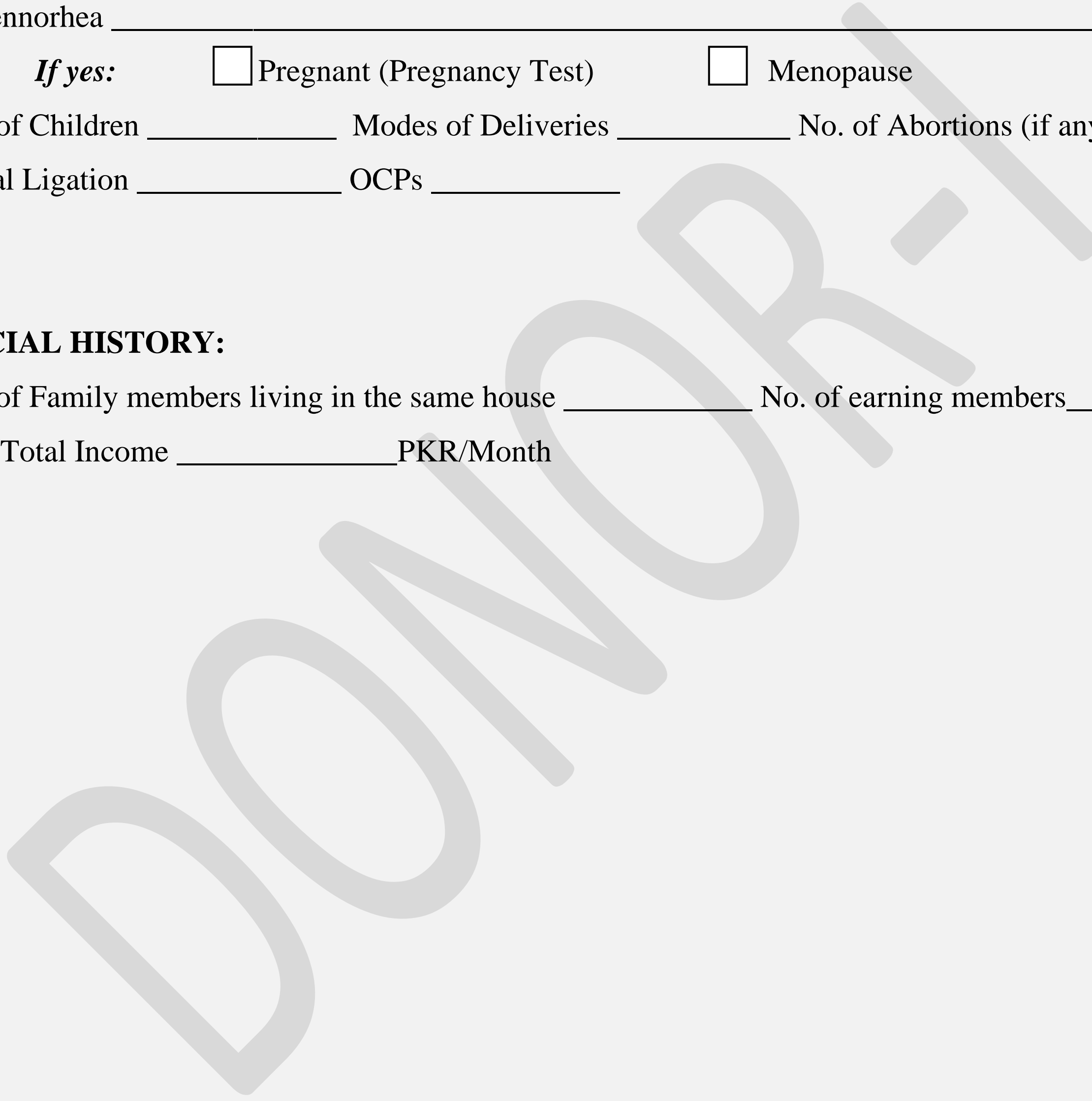
____

CURRENT MEDICATIONS ____

SUBSTANCE ABUSE:

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

DONOR-I



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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Signature & Stamp of Administrator of Hospital

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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DONOR-I

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 __________ Serum Phosphorus _________ Serum PTH (Optional)___________

Serum Iron ____________ TIBC ___________Ferritin _________ Transferrin Sat ___________

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 ____

U/S KUB ____

Chest X-ray ____

Intra Venous Urogram____

Isotope Renal Scan____

Renal Angiography ____

Ascending Urethrogram ____

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:*** __________

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

DONOR-I

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						
BROTHERS						
SISTERS						
SONS						
DAUGHTERS						

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

DONOR

C) CLOSE BLOOD RELATIVE DONOR:

Name:________________________________ S/O, D/O ________________________________

National Identity Card (CNIC) No. __________________________(Attach Attested Photo copy)

Resident of : ____

Age (D.O.B): ________________________Blood Group: __________________(Attach Report)

Tissue Typing: ____

Sex:________________________Referred by: ____________________________(Attach Copy)

Close / Non-Close / Non-Relatives:____

Relations of Donor:

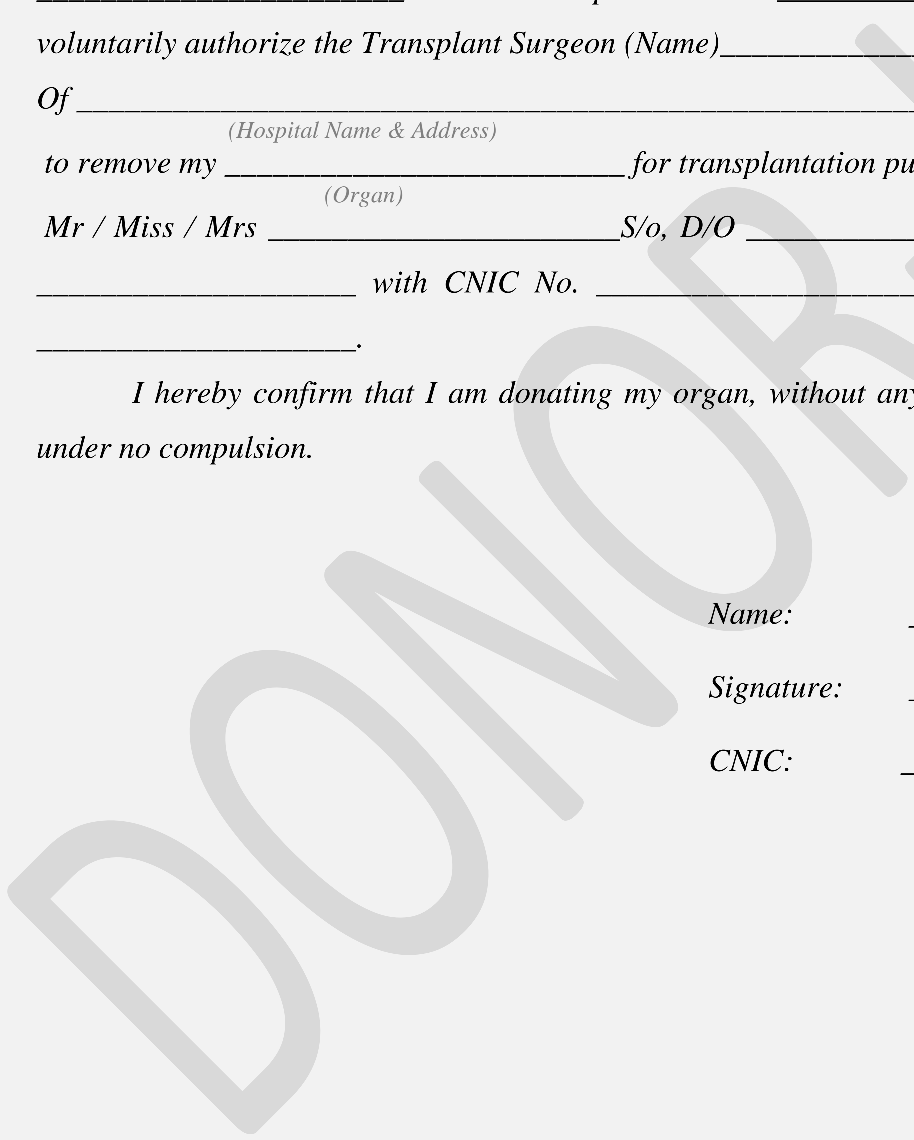
1. Father:____
2. Mother:____
3. Wife / Husband:____

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.

DONOR-I

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 ____
(Hospital Name & Address)
to remove my __________________________ for transplantation purposes to the recipient
(Organ)
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: _____________________

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital