

DONOR FORM (II)

(Recipient being spouse of the Donor)

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	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Body Aches	<input type="checkbox"/>	<input type="checkbox"/>
Generalized Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
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

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

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	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tobacco / Pans	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Naswar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

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 _____

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

SOCIAL HISTORY:

No. of Family members living in the same house _____ No. of earning members _____

Total Income _____PKR/Month

PHYSICAL EXAMINATION

Vital Signs

Pulse _____ Temperature _____ Resp. Rate _____

Blood Pressure _____

Physical Signs

	Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tongue	<input type="checkbox"/>	<input type="checkbox"/>
Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Coated	<input type="checkbox"/>	<input type="checkbox"/>
Koilonychia	<input type="checkbox"/>	<input type="checkbox"/>	Furred	<input type="checkbox"/>	<input type="checkbox"/>
Clubbing	<input type="checkbox"/>	<input type="checkbox"/>	Fissured	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>			
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>			
a. Cervical	<input type="checkbox"/>	<input type="checkbox"/>	Rash		
b. Axillary	<input type="checkbox"/>	<input type="checkbox"/>	Site	_____	
c. Supra-calvicular	<input type="checkbox"/>	<input type="checkbox"/>	Type		
d. Inguinal	<input type="checkbox"/>	<input type="checkbox"/>	Duration		
Enlarged Thyroid	<input type="checkbox"/>	<input type="checkbox"/>			
			Joint Deformities	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Raised JVP	<input type="checkbox"/>	<input type="checkbox"/>			

Systemic Examination

Cardiovascular _____ Respiratory _____

Abdomen _____ Genitourinary _____

Nervous _____ Musculo-Skeletal _____

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

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) HbA1C 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

EVIDENCE REQUIRED FROM SPOUSE DONOR

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 identity and residence of the proposed donor in the form of CNIC or Passport or Driving License.
4. Documentary evidence of relationship including CNIC, Birth Certificates and marriage certificates. (as applicable)
5. Certificate of Interview of one of the next of kin (according to legal definition) of the proposed donor by evaluation committee and all its outcomes. (optional)
6. Certificate of Interview of the donor by evaluation committee and all its outcomes.
7. Certificate from a Psychiatrist to confirm the mental condition and ability to give free consent if desired by Evaluation Committee.
8. 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.
9. In case of dispute or doubt, the Evaluation Committee may demand Microsatellite Gene Analysis certificate to confirm relationship between donor and recipient.

DONOR STATEMENT FOR SPOUSE RECIPIENT

I Mr / Miss / Mrs. _____ *S/O, D/O being the donor, resident of*
_____ *with CNIC NO.*
_____ *and cell phone no* _____ *hereby declare that I am*
the husband of / wife of _____ *the recipient Mr / Miss / Mrs.*
_____ *S/o, D/O* _____ *resident of*
_____ *with CNIC No.* _____ *and cell phone*
no _____.

Name: _____

Signature: _____

CNIC: _____