DONOR FORM (III)

(Non-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 #_____

Angio Access: ☐ Femoral ☐ Jugular ☐ Subclavian ☐ AVC

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

Cardiovascular System

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

Orthopnea ☐ Yes ☐ No Bronchietasis ☐ Yes ☐ No

_____ _____

Signature & Stamp of Transplant Surgeon Signature & Stamp of Administrator of Hospital

Gastro/ Hepatic System

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

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

_____ _____

Signature & Stamp of Transplant Surgeon 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 _____

_____ _____

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 _____

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:*** _____

_____ _____

Signature & Stamp of Transplant Surgeon Signature & Stamp of Administrator of Hospital

DOCUMENTS REQUIRED FOR DONATION OF ORGAN BY NON-CLOSE BLOOD RELATIVES

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) NON-CLOSE BLOOD RELATIVES:

Sr. #	Relation	Name	S/O, D/O, W/O	Blood Group	Reason of Ineligibility*	CNIC #
UNCLES (PATERNAL)						
UNCLES (MATERNAL)						
AUNTS (PATERNAL)						
AUNTS (MATERNAL)						
COUSINS (PATERNAL)						

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

COUSINS (MATERNAL)						
NEPHEWS						
NIECES						
STEP-BROTHERS						
STEP-SISTERS						

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

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 identity and residence of the proposed donor in the form of CNIC or Passport, Driving License and Bank Account Statement.
4. 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)
5. Certificate of Interview of the donor by evaluation committee and all its outcomes.
6. Certificate from a Psychiatrist to confirm the mental condition and ability to give free consent if desired by Evaluation Committee.
7. 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.

_____ _____

Signature & Stamp of Transplant Surgeon Signature & Stamp of Administrator of Hospital

AUTHORIZATION STATEMENT

IN NON-CLOSE BLOOD RELATIVE 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: _____

_____ Signature & Stamp of Transplant Surgeon

_____ Signature & Stamp of Administrator of Hospital