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 # ____________________________ 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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DONOR-III

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?**
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 ___________

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DONOR-II

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	☐	☐	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

DONOR-III

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-II

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)						

DONOR-III

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

DONOR-III

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

C) NON- 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 NON-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, 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 its outcomes. (optional)
5. Certificate of interview of the donor by evaluation committee and 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.

DONOR-III

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 ____

(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

DONOR-III