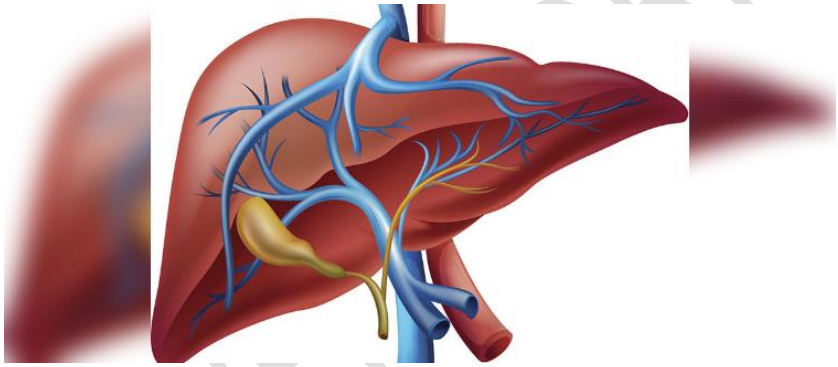
PHOTA
Punjab Human Organ Transplant Authority

Liver Evaluation R-Form

(2018)



Guidelines for the Team Leader

1. Please Filled the R-form completely.
2. Please make sure the Presence of all the representatives of Regional Network Committee.
3. Please make sure any observations /comments apart from those fields in R-Form sent separately to office of PHOTA and these observations cannot be base to Reject or Recommend the case.
4. Please make sure Registration should be strictly on fields included in the R-Form.
5. Please make sure the Signature/initial of Commissioner's Representative on each page of R-form.

Signature of Commissioner's Representative_____

Name of Hospital:_____

Date of visit: _____

Purpose of Visit: Registration of Liver Transplantation.

Sr. #	Items checked	Yes	No
1.	**Accreditation licensing by Punjab Health Care Commission (PHCC)***		
2.	**Disposal of Medical Waste Agreement***		
3.	**Valid Experience Certificates, Degree or other certificates of entire Medical Team related to Organ Transplantation***		
4.	**Performa of PHOTA (filled and complete)***		
5.	**Last Visit / Audit report of PHCC (Punjab Health Care Commission)***		
	Above five mentioned list of items mandatory to proceed further. If any one of them is mentioned NO. Do not Proceed further.		
6.	Record / one year list of donors recipient with contact numbers		
7.	Notification of Infectious Control Committee and its proceedings		
8.	Minutes of Internal Organ Transplant Committee of Institution / hospital		
9.	Previous approval by PHOTA		

Comments (if any): _____

_____

RECOMENDED	NOT RECOMMENDED	RECOMMENDED WITH MINOR CHANGES	RE-VISIT

**Mandatory to Tick ✓ above mentioned Options.

Sr. #	Name of visiting officer	Signature
1.	Commissioner of the Division (Chairman)	
2.	Regional Police Officer or His representative (Member)	
3.	Principal/s of Medical College/s at Divisional level (Member)	
4.	Director Health Services (Member/Secretary)	
5.	One expert of relevant field (Co-opted Member)	

Constitution of Regional Network at Division level According to Notification NO.S.O (H&D) 7-7/2012 of "The Punjab Human Organs and Tissues Act 2012"

Commissioner_____

Signature of Commissioner's Representative_____

CHECKLISTS OF ESSENTIAL STANDARDS FOR GRANT OF CERTIFICATE OF REGISTRATION TO MEDICAL INSTITUTIONS AND HOSPITAL LIVER TRANSPLANTATION

(A) **SOPs and PROCESS DOCUMENTATION:**

PROTOCOLS AND SOPS, FOR EACH OF THE FOLLOWING SEGMENTS WITH NAMES AND QUALIFICATIONS OF PERSONS RESPONSIBLE TO CARRY THEM OUT

Sr. #	SOPs for	Person responsible to implement SOP	Qualification of the person	Yes / No
1.	Donor selection and assessment			Yes ☐ No ☐
2.	Evaluation committee – financial support, and initial screening			Yes ☐ No ☐
3.	Evaluation of donor recipient pair			Yes ☐ No ☐
4.	Pre- procedure care/nutrition/ psychotherapy			Yes ☐ No ☐
5.	Procedure protocols			Yes ☐ No ☐
6.	Post-procedure SOPs			Yes ☐ No ☐
7.	Isolation room SOPs			Yes ☐ No ☐
8.	infection control SOPs for area/surfaces/space/utilities			Yes ☐ No ☐
9.	Mishap reporting SOP			Yes ☐ No ☐
10.	Processes supervision SOPs			Yes ☐ No ☐
11.	Certification from 3rd party clearance (Health Care commission / PHOTA)			Yes ☐ No ☐
12.	Does the hospital administrator know that he is personally responsible for implementation of protocols and procedures			Yes ☐ No ☐

Signature of Commissioner's Representative_____

MANPOWER REQUIREMENTS:

1) Lead Transplant Surgeon

Name	Medical Qualification	Permanent Employee
		Yes ☐ No ☐

Particulars and evidence of Lead Transplant Surgeon-1 provided as detailed below:

Name _____ Date of Birth _____

Qualification: FRCS/FRCP, FCPS, MS/MD, Diplomat American Board or equivalent _____

CNIC _____ PMDC No. _____

Cell No _____ E-Mail _____

Residential Address _____

Official Address _____

i.	Registered with PMDC (valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualifications registered with PMDC	*Enclosed* ☐	*Not enclosed* ☐
iii.	Originals certificates required in serial No. i & ii have been Examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not submitted* ☐

Particulars and evidence of Transplant Surgeon-2 provided as detailed below:

Name	Medical Qualification	Permanent Employee
		Yes ☐ No ☐

Name _____ Date of Birth _____

Qualification: FRCS/FRCP, FCPS, MS/MD, Diplomat American Board or equivalent _____

CNIC _____ PMDC No. _____

Cell No _____ E-Mail _____

Signature of Commissioner's Representative_____

Residential Address

Official Address

		Yes	No
i.	Registered with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in serial No. i & ii have been Examined.	☐	☐
		Submitted	*Not submitted*
iv.	Original experience certificate from competent authority	☐	☐

2) Gastroenterologist

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Gastroenterologist provided as detailed below:

Name Date of Birth

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent

CNIC PMDC No.

Cell No. E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in Sr. No. i & ii have been examined.	☐	☐
		Submitted	*Not Submitted*
iv.	Original experience certificate from competent authority	☐	☐

Signature of Commissioner's Representative_____

3) Medical Specialist

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Medical Specialist provided as detailed below:

Name _____ Date of Birth _____

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent _____

CNIC _____ PMDC No. _____

Cell No. _____ E-Mail _____

Residential Address _____

Official Address _____

i.	Registered with PMDC (valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualifications registered with PMDC	*Enclosed* ☐	*Not Enclosed* ☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not Submitted* ☐

4) Nutritionist:

(Please Tick ✓ the check box) Yes ☐ No ☐

Particulars and evidence of Nutritionist provided as detailed below:

Name _____ Date of Birth _____

Qualification: Master in Human Nutrition, PhD in Human Nutrition or equivalent _____

CNIC _____ E-Mail _____

Signature of Commissioner's Representative_____

Cell No. ☐ Degree Recognized by HEC Yes ☐ No ☐

Residential Address ☐

Official Address ☐

i. Attested copy of Diplomas / certificate of training *Submitted* ☐ *Not submitted* ☐

ii. Attested copy of experience certificate in handling patients *Submitted* ☐ *Not submitted* ☐

iii. Attested copy of Experience certificate *Submitted* ☐ *Not submitted* ☐

5) Anaesthetists

No. of Consultants / Specialists: (Please Tick ✓ the check box)
☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Anesthetist provided as detailed below:

Name ☐ Date of Birth ☐

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent ☐

CNIC ☐ PMDC No. ☐

Cell No. ☐ E-Mail ☐

Residential Address ☐

Official Address ☐

i. Registered with PMDC (valid certificate enclosed) Yes ☐ No ☐

ii. Attested copy of specialist qualifications registered with PMDC *Enclosed* ☐ *Not Enclosed* ☐

iii. Originals certificates required in Sr. No. i & ii have been examined. Yes ☐ No ☐

iv. Original experience certificate from competent authority *Submitted* ☐ *Not Submitted* ☐

Signature of Commissioner's Representative_____

6) Pharmacist:

No. of Pharmacists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Pharmacist provided as detailed below:

Name ☐ Date of Birth ☐

Qualification: D. Pharmacy or equivalent qualification ☐

CNIC ☐ Reg. No. ☐

Cell No. ☐ E-Mail ☐

Residential Address ☐

Official Address ☐

i.	Registered with Pharmacy Council(valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualification registered with Pharmacy Council.	*Enclosed* ☐	*Not Enclosed* ☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not Submitted* ☐

7) Intensivist

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Intensivist provided as detailed below:

Name ☐ Date of Birth ☐

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent ☐

Signature of Commissioner's Representative_____

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

i. Registered appropriately with PMDC (valid certificate enclosed) Yes ☐ No ☐

ii. Attested copy of specialist qualifications registered with PMDC *Enclosed* ☐ *Not Enclosed* ☐

iii. Originals certificates required in Sr. No. i & ii have been examined. Yes ☐ No ☐

Yes ☐ No ☐

iv. Original experience certificate from competent authority *Submitted* ☐ *Not Submitted* ☐

8) Pathologists (Microbiologist/Histopathologist):

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Pathologists (Microbiologist/Histopathologist) provided as detailed below:

Name | Date of Birth

Qualification: FRCPath, FCPS, MD, Diplomat American Board or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

Signature of Commissioner's Representative_____

		Yes	No
i.	Registered with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in Sr. No. i & ii have been examined.	☐	☐
iv.	Original experience certificate from competent authority	*Submitted*	*Not Submitted*
		☐	☐

9) Intervention Radiologist:

No. of Intervention Radiologist: (Please Tick the check box) ✓

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Intervention Radiologist provided as detailed below:

Name _____ Date of Birth _____

Qualification: FRCR, FCPS, MD, Diplomat American Board or equivalent _____

CNIC _____ Reg. No. _____

Cell No. _____ E-Mail _____

Residential Address _____

Official Address _____

		Yes	No
v.	Registered with PMDC/ (valid certificate enclosed)	☐	☐
		Enclosed	*Not Enclosed*
vi.	Attested copy of specialist qualification registered with PMDC/ Pharmacy Council.	☐	☐
		Yes	No
vii.	Originals certificates required in Sr. No. i & ii have been examined.	☐	☐
viii.	Original experience certificate from competent authority	*Submitted*	*Not Submitted*
		☐	☐

Signature of Commissioner's Representative_____

10) Transplant Coordinators/ Bioethic Officer:

(Please Tick ✓ the check box) Yes ☐ No ☐

Particulars and evidence of Transplant Coordinators/ Bioethic Officer provided as detailed below:

Name ☐ Date of Birth ☐

Qualification: MBBS, MSc or equivalent ☐

CNIC ☐ PMDC No. ☐

Cell No. ☐ E-Mail ☐

Residential Address ☐

Official Address ☐

i. Registered appropriately with PMDC in case of medical practitioner Yes ☐ No ☐

ii. Evidence of experience / courses to support essential standards requirement and job description. *Submitted* ☐ *Not submitted* ☐

11) Nursing Staff:

10 a) Nursing Staff-1:

Name	**Qualification**	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-1 provided as detailed below:

Name ☐ Date of Birth ☐

Signature of Commissioner's Representative_____

CNIC		Reg. No.	
Cell No.		E-Mail	
Residential Address			
Official Address			

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	*Submitted* ☐	*Not submitted* ☐
iv.	Experience / Training certificate.	*Submitted* ☐	*Not Submitted* ☐
v.	Transplant operation Theatre experience / Training Certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐
vi.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

10 b) Nursing Staff-2:

Name	**Qualification**	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-2 provided as detailed below:

Name		Date of Birth	
CNIC		Reg. No.	
Cell No.		E-Mail	

Signature of Commissioner's Representative_____

Residential Address

Official Address

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	*Submitted* ☐	*Not submitted* ☐
iv.	Experience / Training certificate.	*Submitted* ☐	*Not Submitted* ☐
v.	Transplant operation Theatre experience / Training Certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐
vi.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

10 c) Nursing Staff-3 / ICU Sister:

Name	**Qualification**	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-3 provided as detailed below:

Name | Date of Birth

CNIC | Reg. No.

Cell No. | E-Mail

Residential Address

Official Address

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	*Submitted* ☐	*Not submitted* ☐
iv.	Experience / Training certificate.	*Submitted* ☐	*Not Submitted* ☐

Signature of Commissioner's Representative_____

v.	Transplant operation Theatre experience / Training Certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐
vi.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

12) Data Entry / Computer Operator:

(Please Tick ✓ the check box) Yes ☐ No ☐

Particulars and evidence of Data Entry / Computer Operator provided as detailed below:

Name ☐ Date of Birth ☐

CNIC ☐ E-Mail ☐

Cell No. ☐

Residential Address ☐

Official Address ☐

i.	Attested copy of Graduate qualification	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of Microsoft office certificate.	*Submitted* ☐	*Not submitted* ☐
iii.	Attested copy of Experience certificate	*Submitted* ☐	*Not submit* ☐

Signature of Commissioner's Representative_____

B) EQUIPMENT REQUIREMENT:

1 Laboratory Service:

	Availability (Certificate to be provided by the hospital)		**Functionality** (Certificate to be provided be the hospital)	
Hematology Cell Counter	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Chemistry Analyzer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Electrolyte Analyzer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Blood Gas Analyzer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Blood Bank Fridges 4.C	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Blood Cell Saver				
ELISA Plate reader and washer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Dissection microscope	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Tissue processor, manual or preferably automated	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Tissue embedding center	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Microtome	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Cold Centrifuge	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Micro Centrifuge	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Microscope Fluorescent	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Microscopes	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Roller Mixers	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Automatic pipettes	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐

Signature of Commissioner's Representative_____

2) Radiology Department:

	Availability (Certificate to be provided by the hospital)		Functionality (Certificate to be provided be the hospital)	
X-ray machine / Digital X-ray / Mobile X-ray	Present ☐	Not Present ☐	Functioning ☐	Not Functioning ☐
Doppler ultrasound machine with needle guide	Present ☐	Not Present ☐	Functioning ☐	Not Functioning ☐

***Disposables / Materials*:**

Contrast material for T Tube Cholangiogram	Provided ☐	Not Provided ☐
Biopsy needle and gun	Provided ☐	Not Provided ☐
Sterilizing kits with gauze, pyodine, sterile gloves opsite, syringes	Provided ☐	Not Provided ☐
PTBD / drainage packs.	Provided ☐	Not Provided ☐

3) Anesthesia Department:

	Availability (Certificate to be provided by the hospital)		Functionality (Certificate to be provided be the hospital)	
Anesthesia machine and its affiliated functions (preferably with computerized ventilator) Machine with central supply of oxygen and oxygen cylinder Vaporizer (Cervoflurance, Isoflurane) Oxygen failure arm N2O cut of device Anti-hypoxic device	Present ☐	Not Present ☐	Functioning ☐	Not Functioning ☐
Ventilator (Digital or manual) with following features: Gas/ electric driven Tidal volume adjustment Ventilation mode adjustment Inspiratory / expiratory ratio Inspiratory flow rate	Present ☐	Not Present ☐	Functioning ☐	Not Functioning ☐

Signature of Commissioner's Representative_____

Monitoring devices:	Present	Not present	Functioning	Not Functioning
ECG Pulse oximetery End Tidal CO_2 Non-invasive BP monitor Invasive BP monitor Temperature monitor (surface and Core)	☐	☐	☐	☐
Central venous pressure monitor Suction Machine	Present	Not present	Functioning	Not Functioning
	☐	☐	☐	☐

Warming Devices:	Present	Not present	Functioning	Not Functioning
Fluid warming cabinet Transfusion warmer Warming mattress Warming Blanket Worm air bler	☐	☐	☐	☐

***Disposables / Materials*:**

Airway management gadgets (laryngoscope, Bougie, Styllets, Endotracheal tubes, Laryngeal masks, Fiberoptic laryingo scope etc)	Provided ☐	Not Provided ☐
Reserve gas cylinders (O_2, N_2O, Air)	Provided ☐	Not Provided ☐
Infusion pumps	Provided ☐	Not Provided ☐
Syringe pumps	Provided ☐	Not Provided ☐
Nerve stimulators	Provided ☐	Not Provided ☐
CVP catheters (double and triple lumen)	Provided ☐	Not Provided ☐

Signature of Commissioner's Representative_____

4) Pharmacy Department:

The pharmacy must provide the following minimum requirements.

Disposables/ Materials:

IV anesthetic agents Thiopentone Propofol	Provided ☐	Not Provided ☐
Narcotics	Provided ☐	Not Provided ☐
Non depolarizer muscle relaxants	Provided ☐	Not Provided ☐
Inotrops Dopamine Dobutamine Phenyl ephrine Adrenaline Nor epinephrine	Provided ☐	Not Provided ☐
Beta Blockers Inj. Labetalol Inderal)	Provided ☐	Not Provided ☐
Vasodilators GTN Hydralazine Nitro Prusside	Provided ☐	Not Provided ☐
Local anesthetic Bupivaccin Xylocaine	Provided ☐	Not Provided ☐
Naloxone	Provided ☐	Not Provided ☐
Calcium chloride	Provided ☐	Not Provided ☐
Mg SO_4	Provided ☐	Not Provided ☐
Immunosuppressive drugs.	Provided ☐	Not Provided ☐
Urine bags, Catheters	Provided ☐	Not Provided ☐
Liver Dialysis Devices (MARS, SPAD)	Provided ☐	Not Provided ☐
Anti-biotic, Anti-viral and Anti-fungal agents	Provided ☐	Not Provided ☐
Endotracheal tubes, Laryngeal masks, Central Venous Catheters	Provided ☐	Not Provided ☐
Dressings	Provided ☐	Not Provided ☐

5) Intensive Care Unit:

At least four bedded facility for 48 hours intensive care	Provided ☐	Not Provided ☐

Signature of Commissioner's Representative_____

Maneuverable bed equipped with facility for cardiac monitoring, invasive monitoring, NIBP and Oximetry.	Provided ☐	Not Provided ☐
Stand by ventilator	Provided ☐	Not Provided ☐
Basic resuscitation trolley Complete in every respect as defined in Annexure……	Provided ☐	Not Provided ☐

6) Operation Theatre Department: Minimum Surgical Instrument required for liver transplantation & Preservatives.

i. Liver Preservatives: UW Solution(Viaspan)	Provided ☐	Not Provided ☐
ii. Basic General Set for Operation Theatre		
iii. Vascular Instruments for Liver Transplant:	Provided ☐	Not Provided ☐
Reynolds Scissors CVD 175 mm	Present ☐	Not Present ☐
Arteriotomy scissors Debakey CVD 175mm	Present ☐	Not Present ☐
Durotip Scissors 220mm CVD	Present ☐	Not Present ☐
NonTraumatic Vessel Forceps 150mm	Present ☐	Not Present ☐
Durogrip forceps 20 cm Slender Type	Present ☐	Not Present ☐
Durogrip Dissecting Forceps 180mm	Present ☐	Not Present ☐
Baby Mixture Forceps 140 mm	Present ☐	Not Present ☐
Jacobson Needle Holder W. Catch 185mm	Present ☐	Not Present ☐
Durogrip Debakey Needle holder 230mm	Present ☐	Not Present ☐
Durogrip Debakey Needle holder 250mm	Present ☐	Not Present ☐
Durogrip Needle Holder Ryder 155mm Delic	Present ☐	Not Present ☐
ATR Neonatal Miniature Forceps Small	Present ☐	Not Present ☐
ATR Neonatal Miniature Forceps Medium	Present ☐	Not Present ☐

Signature of Commissioner's Representative_____

ATR Neonatal Miniature Forceps Large	Present ☐	Not Present ☐
ATR Neonatal Miniature Forceps Clamp Curved	Present ☐	Not Present ☐
Non Traum Forceps cooley 90 Degree Small 165mm	Present ☐	Not Present ☐
De Bakey Buldog Clamp Curved 50mm	Present ☐	Not Present ☐
A TR Buldog Clamp De Bakey CVD	Present ☐	Not Present ☐
A TR Buldog Clamp De Bakey CVD 23/78mm	Present ☐	Not Present ☐
A TR Buldog Clamp De Bakey CVD 31/86mm	Present ☐	Not Present ☐
A TR Buldog Clamp De Bakey CVD 42/97mm	Present ☐	Not Present ☐
Stanskey Vena-Cava Clamp Large	Present ☐	Not Present ☐
Stanskey Vena-Cava Clamp Medium	Present ☐	Not Present ☐
Stanskey Vena-Cava Clamp Large	Present ☐	Not Present ☐
Potts Scissors on Angle	Present ☐	Not Present ☐
Watson-Cheyon probe and Dissector	Present ☐	Not Present ☐
Omnai- Track Self Retaining Retactor (for vascular procedure)	Present ☐	Not Present ☐
Sterile Ice making Machine	Present ☐	Not Present ☐

Signature of Commissioner's Representative_____

	Present	Not Present
De Bakey Buldog Clamp (Cross Action)	☐	☐
Thompson Retractor		
Special Liver Resection Devices:	☐	☐
CUSA (Cavitron Ultrasonic Aspirator)	☐	☐
Bipolar Vessel Sealing System (Ligasure, Valley Lab)	☐	☐
Harmonic Device	☐	☐
Water Jet Scalpel	☐	☐
Intraoperative Ultrasound Probe	☐	☐
Argon Beam Coagulation Continous Renal Replacement Therapy	☐	☐

C) SPECIALIZED SERVICES AND FACILITIES:

The hospital administrator will ensure satisfactory provision of the following services and facilities.

1) Laboratory Service:

The Hematology, Microbiology, Chemical Pathology and Histopathology Sections must be available and functional.

i.	**HEMATOLOGY: (Mandatory)**	Yes	No
	Routine Blood Counts / Peripheral films	☐	☐
	Screening for sick cell / haemoglobino patients/ Malaria Parasites	Yes ☐	No ☐
ii.	**Microbiology:**	Yes	No
	Culture and Sensitivity	☐	☐
iii.	**Chemical pathology: (Mandatory)**	Yes	No
	Biochemical Investigations	☐	☐
	Organ Function Tests	Yes ☐	No ☐
	24 hours urinary analysis	Yes ☐	No ☐
iv.	**Histopathology:**	Provided	Not Provided
	Routine processing and reporting of biopsy	☐	☐
	Cytology specimens process and reporting	Provided ☐	Not Provided ☐
v.	**Immunology:**	Provided	Not Provided
	Tissue typing	☐	☐
	Immunosuppressive drug monitoring	Provided ☐	Not Provided ☐
	Molecular diagnostic facilities	Provided ☐	Not Provided ☐
	24 hours availability of laboratory	Yes ☐	No ☐

Signature of Commissioner's Representative_____

2) Operation Theatre And Anesthesia Department:

i.	Minimum two operating theatres	Provided ☐	Not Provided ☐
ii.	Separate theatre available for transplant procedures only	Provided ☐	Not Provided ☐
iii.	State of sterilization: Autoclave	Provided ☐	Not Provided ☐
	Operating instructions	Provided ☐	Not Provided ☐
	Maintenance certificate	Provided ☐	Not Provided ☐
	Quality control on efficacy of sterilization	Provided ☐	Not Provided ☐
iv.	SOPs of Operation Theatre	Provided ☐	Not Provided ☐
v.	Theatre personnel: Minimum of 6 trained staff Nurses	Provided ☐	Not Provided ☐
	Minimum of 4 Operation Theatre Assistants	Provided ☐	Not Provided ☐
	Minimum of 6 ancillary staff	Provided ☐	Not Provided ☐
vi.	Minimum of 2 electronically operated operation tables with high quality light devices	Provided ☐	Not Provided ☐
vii.	Minimum of 3 patient trolley	Provided ☐	Not Provided ☐
viii.	Patient lifting devices	Provided ☐	Not Provided ☐
ix.	Fridge / Freezer to produce ice	Provided ☐	Not Provided ☐
x.	Minimum of 4 bedded Recovery Room / High Dependency Unit, equipped with oxygen supply and monitoring devices.	Provided ☐	Not Provided ☐
xi.	Designated Scrub, changing and storage areas	Provided ☐	Not Provided ☐
xii.	Reception and rest areas	Provided ☐	Not Provided ☐
xiii.	Minimum of 2 Anesthetic rooms	Provided ☐	Not Provided ☐

3) Liver Transplant Ward:

i.	Defibrillator, Cardiac Monitor, ECG machine, Pulse Oximeter, Weighing Machine, Portable IV stands, Wheel Chairs, X-Ray Illuminator, VCP manometer, Easy chairs for patients and foot steps, Nebulizer, Spirometer, Staff (Receptionist, Ward Boys, Ayas, Sweepers, Peons)	Provided ☐	Not Provided ☐

Signature of Commissioner's Representative_____

4) Blood Bank:

Hospital should have blood bank facilities or proper arrangements with recognized blood bank with proper storage facility.

i.	Typing and cross matching tests	Yes ☐	No ☐
ii.	Blood storage facility	Yes ☐	No ☐
iii.	Cell separator	Yes ☐	No ☐
iv.	Ability to provide blood components	Yes ☐	No ☐

5) Record Keeping: According to Proforma provided

i.	List of operations performed in the last 12 months	Provided ☐	Not Provided ☐
ii.	List of dialysis performed in the last 12 months	Provided ☐	Not Provided ☐
iii.	Record of morbidity mortality and audit meetings	Provided ☐	Not Provided ☐

6) Library and other Resources:

i.	Computers	Provided ☐	Not Provided ☐
ii.	Internet Access	Provided ☐	Not Provided ☐
iii.	24 hours availability of communication system, with power backup.	Provided ☐	Not Provided ☐
iv.	Public telephone systems	Provided ☐	Not Provided ☐
v.	Fax Machine	Provided ☐	Not Provided ☐
vi.	Photo-imaging machine	Provided ☐	Not Provided ☐
vii.	Advisory and committee room with 8-10 chairs (For patient related meeting)	Provided ☐	Not Provided ☐

Signature of Commissioner's Representative_____