

# RECIPIENT 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 # \_\_\_\_\_

**ACTIVE COMPLAINT**

**Complaint**

**Present**

**Absent**

Nausea / Vomiting

Decreased Appetite

Jaundice

Generalized Weakness

Fever

Haemetemesis/Malaena

Abdominal distension

Any Other \_\_\_\_\_

**CAUSE OF END ORGAN FAILURE** \_\_\_\_\_

**BRIEF HISTORY OF ILLNESS LEADS TO LIVER FAILURE:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature & Stamp of Transplant Surgeon

\_\_\_\_\_  
Signature & Stamp of Administrator of Hospital

**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 Bronchiectasis  Yes  No

**Cardiovascular System**

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

**Gastro / Hepatic System**

Jaundice  Yes  No Chronic Diarrhea  Yes  No  
 Back Stools  Yes  No Ascites  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 \_\_\_\_\_

\_\_\_\_\_  
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**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  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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**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"/> |                   |                              |                             |
| Raised JVP          | <input type="checkbox"/> | <input type="checkbox"/> | Joint Deformities | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**Systemic Examination**

Cardiovascular \_\_\_\_\_ Respiratory \_\_\_\_\_  
 Abdomen \_\_\_\_\_ Genitourinary \_\_\_\_\_  
 Nervous \_\_\_\_\_ Musculo-Skeletal \_\_\_\_\_

\_\_\_\_\_  
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\_\_\_\_\_  
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**INVESTIGATIONS:**

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

**INVESTIGATIONS TO BE DONE ON ALL PATIENTS:**

Blood type and antibody screen: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ PCV: \_\_\_\_\_ MCV: \_\_\_\_\_

WBC: \_\_\_\_\_ DLC: P \_\_\_\_\_ L \_\_\_\_\_ M \_\_\_\_\_ E \_\_\_\_\_

Platelet count: \_\_\_\_\_ PT, APTT: \_\_\_\_\_ INR: \_\_\_\_\_

Na \_\_\_\_\_ K \_\_\_\_\_ Cl \_\_\_\_\_ HCO<sub>3</sub> \_\_\_\_\_ Ca \_\_\_\_\_ PO<sub>4</sub> \_\_\_\_\_

Urea \_\_\_\_\_ Creatinine \_\_\_\_\_ Established GFR \_\_\_\_\_

LFT's: Total bilirubin \_\_\_\_\_ Directbil. \_\_\_\_\_ ALT \_\_\_\_\_ AST \_\_\_\_\_ Alk.Phos. \_\_\_\_\_

GGT \_\_\_\_\_ Total proteins \_\_\_\_\_ Albumin \_\_\_\_\_ A/G ratio \_\_\_\_\_

BSR \_\_\_\_\_ CK \_\_\_\_\_ Serum amylase \_\_\_\_\_

AFP \_\_\_\_\_ CEA \_\_\_\_\_ PSA \_\_\_\_\_ Urinalysis \_\_\_\_\_

Stools for occult blood #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Tuberculin skin test \_\_\_\_\_ TB Quantiferon test \_\_\_\_\_

VIROLOGY: HBsAg \_\_\_\_\_ anti-HBc total \_\_\_\_\_ Anti-HBs \_\_\_\_\_ anti-HCV \_\_\_\_\_

HCVRNA \_\_\_\_\_ anti-HAV total \_\_\_\_\_ CMV IgG \_\_\_\_\_ EBV IgG \_\_\_\_\_

Anti-HIV 1 and HIV 2 \_\_\_\_\_

Duplex ultrasound of abdomen: \_\_\_\_\_

CT scan of abdomen: \_\_\_\_\_

ECG: \_\_\_\_\_ CXR: \_\_\_\_\_ Echocardiogram: \_\_\_\_\_ Mammogram: \_\_\_\_\_

Upper and lower GI endoscopies: \_\_\_\_\_

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**INVESTIGATIONS ON SELECTED PATIENTS:**

ANA, anti-mitochondrial antibody, anti-smooth muscle antibody

HBeAg, anti-HBe, HBV-DNA, anti-delta, anti-HAV-IgM

Serum iron, TIBC, serum ferritin

Alpha 1- antitrypsin level

Serum ceruloplasmin level

Complete pulmonary function studies

Stress thallium scanning, coronary angiography

Angiogram/ Magnetic resonance angiogram (as indicated)

**CONSULTS AND ASSESSMENTS:**

Consult Anaesthesia/Intensivist

Consult Dentistry

Consult transplant Dietician

Consult transplant Psychologist

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