# 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 # _____ 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 _____

**CAUSE OF END ORGAN FAILURE**_____

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

_____

_____

_____

_____

_____

_____

_____





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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 | Bronchietasis | ☐ Yes | ☐ No |

**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 _____





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**SUBSTANCE ABUSE:**

| | Yes | No | Amount / Day | Since When? |
|---|---|---|---|---|
| Cigeratte / Hukka | ☐ | ☐ | _____ | _____ |
| Tobacco / Pans | ☐ | ☐ | _____ | _____ |
| Naswar | ☐ | ☐ | _____ | _____ |
| Heroin | ☐ | ☐ | _____ | _____ |
| Marijuana | ☐ | ☐ | _____ | _____ |
| Alcohol | ☐ | ☐ | _____ | _____ |

**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 | ☐ | ☐ | 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 _____





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# 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 _____

RBs _____

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 _____

**If Recipient 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* _____**



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# CLOSE BLOOD RELATIVE RECIPIENT:

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 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 relationship including CNIC, Birth Certificates and marriage certificates. (as applicable)
4. Documentary evidence of identity and residence of the proposed donor in the form of CNIC or Passport or Driving License.
5. In case of dispute or doubt, the Evaluation Committee may demand Microsatellite Gene Analysis certificate to confirm relationship between donor and recipient.
6. 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.





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