

# RECIPIENT FORM (II)

(Recipient being spouse of the donor)

*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	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Generalized Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Haemetemesis/Malaena	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>

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 Bronchietasis  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 \_\_\_\_\_

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

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

**SUBSTANCE ABUSE:**

	<b>Yes</b>	<b>No</b>	<b>Amount / Day</b>	<b>Since When?</b>
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 \_\_\_\_\_

Amenorrhea \_\_\_\_\_

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

\_\_\_\_\_  
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	<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 \_\_\_\_\_

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

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

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

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

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

**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

---

Signature & Stamp of Transplant Surgeon

---

Signature & Stamp of Administrator of Hospital

## **EVIDENCE REQUIRED FROM SPOUSE RECIPIENT**

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. (on applicable)
4. Documentary evidence of identity and residence of the proposed donor in the form of CNIC or Passport or Driving License.
5. Certificate of interview of one of the next of kin (according to legal definitions) of the proposed donor by evaluation committee and its outcomes. (optional)
6. Certificate of Interview of the donor by evaluation committee and its outcomes.
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.
8. Photo identity and thumb impression of the recipient.
9. In case of dispute or doubt, the Evaluation Committee may demand Microsatellite Gene Analysis certificate to confirm relationship between donor and recipient.

---

Signature & Stamp of Transplant Surgeon

---

Signature & Stamp of Administrator of Hospital