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 # ___________________________ 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 Transplant Surgeon

Signature & Stamp of Administrator of Hospital

RECIPIENT-II

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			

RECIPIENT-II

PAST SURGICAL HISTORY ____

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CURRENT MEDICATIONS ____

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

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

RECIPIENT-II

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	☐	☐	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

RECIPIENT-II

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*** _____________

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

RECIPIENT-II

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. (as 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 definition) 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.

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Signature & Stamp of Administrator of Hospital