RECIPIENT FORM (III)

(Non-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	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 _____

_____ _____

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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 _____

_____ 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_____ HCO3 _____ Ca_____ PO4 _____

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 ferririn

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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NON-CLOSE BLOOD RELATIVES RECIPIENT:

Name: _____ S/o, D/o _____

National Identity Card (CNIC) No. _____ (Attach Attested Photocopy)

Resident of: _____

Age (D.O.B): _____ Blood Group: _____ (Attached Report)

Tissue Typing: _____

Sex: _____ Referred by: _____ (Attached Copy)

Close / Non-Close / Non –Relatives: _____

Relations of Recipient:

1. Father: _____
2. Mother: _____
3. Wife / Husband: _____

EVIDENCE REQUIRED FROM NON-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. 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)
4. Certificate of interview of the donor by evaluation committee and its outcomes.
5. Attested photographs for HOTA specifications and thumb impression of the donor in presence of two witnesses.

_____ _____

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