

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 # _____ 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:

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 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 _____

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital

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 _____

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"/>	Rash		
a. Cervical	<input type="checkbox"/>	<input type="checkbox"/>	Site	_____	
b. Axillary	<input type="checkbox"/>	<input type="checkbox"/>	Type		
c. Supra-calvicular	<input type="checkbox"/>	<input type="checkbox"/>	Duration		
d. Inguinal	<input type="checkbox"/>	<input type="checkbox"/>			
Enlarged Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Joint Deformities	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Raised JVP	<input type="checkbox"/>	<input type="checkbox"/>			

Systemic Examination

Cardiovascular _____ Respiratory _____

Abdomen _____ Genitourinary _____

Nervous _____ Musculo-Skeletal _____

Signature & Stamp of Transplant Surgeon

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HOTA (PUNJAB) Kidney Transplantation
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) HbA1C 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

NON-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 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 specification and thumb impression of the donor in presence of two witnesses.

Signature & Stamp of Transplant Surgeon

Signature & Stamp of Administrator of Hospital