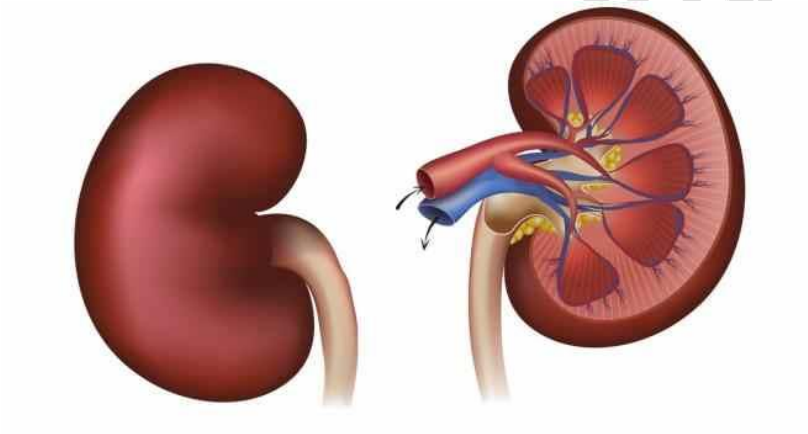
PHOTA
Punjab Human Organ Transplant Authority

Renal Evaluation R-Form

(2018)



Guidelines for the Team Leader

1. Please Filled the R-form completely.
2. Please make sure the Presence of all the representatives of Regional Network Committee.
3. Please make sure any observations /comments apart from those fields in R-Form sent separately to office of PHOTA and these observations cannot be base to Reject or Recommend the case.
4. Please make sure Registration should be strictly on fields included in the R-Form.
5. Please make sure the Signature/initial of Commissioner's Representative on each page of R-form.

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Signature of Commissioner's Representative_____

Name of Hospital: _____

Date of visit: _____

Purpose of Visit: Registration of Renal Transplantation.

Sr. #	Items checked	Yes	No
1.	**Accreditation licensing by Punjab Health Care Commission (PHCC)***		
2.	**Disposal of Medical Waste Agreement***		
3.	**MoU Tissue Typing (in case of Renal Transplantation)***		
4.	**Valid Experience Certificates, Degree or other certificates of entire Medical Team related to Organ Transplantation***		
5.	**Performa of PHOTA (filled and complete)***		
6.	**Last Visit / Audit report of PHCC (Punjab Health Care Commission)***		
	Above six mentioned list of items mandatory to proceed further. If any one of them is mentioned NO. Do not Proceed further.		
7.	Record / one year list of donors recipient with contact numbers		
8.	Notification of Infectious Control Committee and its proceedings		
9.	Minutes of Internal Organ Transplant Committee of Institution / hospital		
10.	Previous approval by PHOTA		

Comments (if any): _____

_____

RECOMENDED	NOT RECOMMENDED	RECOMMENDED WITH MINOR CHANGES	RE-VISIT

**Mandatory to Tick ✓ above mentioned Options.

Sr. #	Name of visiting officer	Signature
1.	Commissioner of the Division (Chairman)	
2.	Regional Police Officer or His representative (Member)	
3.	Principal/s of Medical College/s at Divisional level (Member)	
4.	Director Health Services (Member/Secretary)	
5.	One expert of relevant field (Co-opted Member)	

Constitution of Regional Network at Division level According to Notification NO.S.O (H&D) 7-7/2012 of "The Punjab Human Organs and Tissues Act 2012"

Commissioner_____

Signature of Commissioner's Representative_____

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CHECKLISTS OF ESSENTIAL STANDARDS FOR GRANT OF CERTIFICATE OF REGISTRATION TO MEDICAL INSTITUTIONS AND HOSPITAL KIDNEY TRANSPLANTATION

(A) **SOPs and PROCESS DOCUMENTATION:**

PROTOCOLS AND SOPS, FOR EACH OF THE FOLLOWING SEGMENTS WITH NAMES AND QUALIFICATIONS OF PERSONS RESPONSIBLE TO CARRY THEM OUT

Sr. #	SOPs for	Person responsible to implement SOP	Qualification of the person	Yes / No
1.	Donor selection and assessment			Yes ☐ No ☐
2.	Evaluation committee – financial support, and initial screening			Yes ☐ No ☐
3.	HLA and other Tissue matching investigations			Yes ☐ No ☐
4.	Evaluation of donor recipient pair			Yes ☐ No ☐
5.	Pre- procedure care/nutrition/ psychotherapy			Yes ☐ No ☐
6.	Procedure protocols			Yes ☐ No ☐
7.	Post-procedure SOPs			Yes ☐ No ☐
8.	Isolation room SOPs			Yes ☐ No ☐
9.	infection control SOPs for area/surfaces/space/utilities			Yes ☐ No ☐
10.	Mishap reporting SOP			Yes ☐ No ☐
11.	Processes supervision SOPs			Yes ☐ No ☐
12.	Certification from 3rd party clearance (Health Care commission / PHOTA)			Yes ☐ No ☐
13.	Does the hospital administrator know that he is personally responsible for implementation of protocols and procedures			Yes ☐ No ☐

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(B) MANPOWER REQUIREMENTS:

1) Lead Transplant Surgeon

Name	Medical Qualification	Permanent Employee
		Yes ☐ No ☐

Particulars and evidence of Lead Transplant Surgeon-1 provided as detailed below:

Name _____ Date of Birth _____

Qualification: FRCS/FRCP, FCPS, MS/MD, Diplomat American Board or equivalent _____

CNIC _____ PMDC No. _____

Cell No _____ E-Mail _____

Residential Address _____

Official Address _____

i.	Registered with PMDC (valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualifications registered with PMDC	*Enclosed* ☐	*Not enclosed* ☐
iii.	Originals certificates required in serial No. i & ii have been Examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not submitted* ☐

Particulars and evidence of Transplant Surgeon-2 provided as detailed below:

Name	Medical Qualification	Permanent Employee
		Yes ☐ No ☐

Name _____ Date of Birth _____

Qualification: FRCS/FRCP, FCPS, MS/MD, Diplomat American Board or equivalent _____

CNIC _____ PMDC No. _____

Signature of Commissioner's Representative_____

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Cell No | E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in serial No. i & ii have been Examined.	☐	☐
iv.	Original experience certificate from competent authority	*Submitted*	*Not submitted*
		☐	☐

2) Nephrologists

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Nephrologist provided as detailed below:

Name | Date of Birth

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in i & ii have been examined.	☐	☐
iv.	Original experience certificate from competent authority	*Submitted*	*Not Submitted*
		☐	☐

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3) General Physicians

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Consultants / Specialists provided as detailed below:

Name | Date of Birth

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

i.	Registered appropriately with PMDC (valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualifications registered with PMDC	*Enclosed* ☐	*Not Enclosed* ☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not Submitted* ☐

4) Anaesthetists

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Anesthetist provided as detailed below:

Name | Date of Birth

Qualification: MRCP, FRCP, FCPS, MD, Diplomat American Board or equivalent

Signature of Commissioner's Representative_____

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CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered appropriately with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in Sr. No. i & ii have been examined.	☐	☐
		Submitted	*Not Submitted*
iv.	Original experience certificate from competent authority	☐	☐

5) Radiologists

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Radiologist provided as detailed below:

Name | Date of Birth

Qualification: FRCR, FCPS, MD, Diplomat American Board or equivalent

CNIC | PMDC No.

Cell No. | E-Mail

Residential Address

Official Address

		Yes	No
i.	Registered appropriately with PMDC (valid certificate enclosed)	☐	☐
		Enclosed	*Not Enclosed*
ii.	Attested copy of specialist qualifications registered with PMDC	☐	☐
		Yes	No
iii.	Originals certificates required in Sr. No. i & ii have been examined.	☐	☐

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iv. Original experience certificate from competent authority *Submitted* ☐ *Not Submitted* ☐

6) Pathologists:

No. of Consultants / Specialists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

Particulars and evidence of Pathologist provided as detailed below:

Name _____ Date of Birth _____

Qualification: FRCPath, FCPS, MD, Diplomat American Board or equivalent _____

CNIC _____ PMDC No. _____

Cell No. _____ E-Mail _____

Residential Address _____

Official Address _____

i. Registered appropriately with PMDC (valid certificate enclosed) Yes ☐ No ☐

ii. Attested copy of specialist qualifications registered with PMDC *Enclosed* ☐ *Not Enclosed* ☐

iii. Originals certificates required in Sr. No. i & ii have been examined. Yes ☐ No ☐

iv. Original experience certificate from competent authority *Submitted* ☐ *Not Submitted* ☐

7) Pharmacist:

No. of Pharmacists: (Please Tick ✓ the check box)

☐ 1 ☐ 2 ☐ 3

Yes ☐ No ☐

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Particulars and evidence of Pharmacist provided as detailed below:

Name		Date of Birth	
Qualification: D. Pharmacy or equivalent qualification			
CNIC		Reg. No.	
Cell No.		E-Mail	
Residential Address			
Official Address			

i.	Registered appropriately with Pharmacy Council(valid certificate enclosed)	Yes ☐	No ☐
ii.	Attested copy of specialist qualification registered with Pharmacy Council.	*Enclosed* ☐	*Not Enclosed* ☐
iii.	Originals certificates required in Sr. No. i & ii have been examined.	Yes ☐	No ☐
iv.	Original experience certificate from competent authority	*Submitted* ☐	*Not Submitted* ☐

8) Transplant Coordinators:

(Please Tick ✓ the check box)

Yes ☐ No ☐

Particulars and evidence of Transplant Coordinator provided as detailed below:

Name		Date of Birth	
Qualification: MBBS, MSc or equivalent			
CNIC		PMDC No.	
Cell No.		E-Mail	
Residential Address			

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Official Address

		Yes	No
i.	Registered appropriately with PMDC in case of medical practitioner	☐	☐
		Submitted	*Not submitted*
ii.	Evidence of experience / courses to support essential standards requirement and job description.	☐	☐

9) Nursing Staff:

11 a) Nursing Staff-1:

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-1 provided as detailed below:

Name | Date of Birth

CNIC | Reg. No.

Cell No. | E-Mail

Residential Address

Official Address

		Submitted	*Not submitted*
i.	valid certificate of registration with the Nursing Council	☐	☐
ii.	Attested copy of original Nursing and matriculation qualification.	☐	☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	☐	☐
iv.	Experience / Training certificate in handling patients on dialysis.	☐	☐
v.	Transplant operation Theatre experience / Training Certificate. Wherever applicable.	☐	☐
vi.	ICU Training certificate. Wherever applicable.	☐	☐

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11 b) Nursing Staff-2:

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of all nursing staff-2 provided as detailed below:

Name _____ Date of Birth _____

CNIC _____ Reg. No. _____

Cell No. _____ E-Mail _____

Residential Address _____

Official Address _____

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	*Submitted* ☐	*Not submitted* ☐
iv.	Experience / Training certificate in handling patients on dialysis.	*Submitted* ☐	*Not Submitted* ☐
v.	Transplant operation Theatre experience / Training Certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐
vi.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

11 c) Nursing Staff-3 / ICU Sister:

Name	Qualification	Yes	No
		☐	☐

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Particulars and evidence of all nursing staff-3 provided as detailed below:

Name | Date of Birth

CNIC | Reg. No.

Cell No. | E-Mail

Residential Address

Official Address

i.	valid certificate of registration with the Nursing Council	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of original Nursing and matriculation qualification.	*Submitted* ☐	*Not submitted* ☐
iii.	Experience / Training certificate to confirm exposure to managing Transplant operations preoperatively.	*Submitted* ☐	*Not submitted* ☐
iv.	Experience / Training certificate in handling patients on dialysis.	*Submitted* ☐	*Not Submitted* ☐
v.	Transplant operation Theatre experience / Training Certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐
vi.	ICU Training certificate. Wherever applicable.	*Submitted* ☐	*Not Submitted* ☐

10) Data Entry / Computer Operator:

Yes ☐ No ☐

Particulars and evidence of Data Entry / Computer Operator provided as detailed below:

Name | Date of Birth

CNIC | E-Mail

Cell No.

Residential Address

Official Address

i.	Attested copy of Graduate qualification	*Submitted* ☐	*Not submitted* ☐
ii.	Attested copy of Microsoft office certificate.	*Submitted* ☐	*Not submitted* ☐
iii.	Attested copy of Experience certificate	*Submitted* ☐	*Not submitted* ☐

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11) Dialysis Technicians:

13 a) Dialysis Technician-1

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of Dialysis Technician-1 provided as detailed below:

Name ☐ Date of Birth ☐

CNIC ☐ E-Mail ☐

Cell No. ☐

Residential Address ☐

Official Address ☐

		Submitted	*Not submitted*
i.	Attested copy of Diplomas / certificate of training in dialysis	☐	☐
ii.	Attested copy of experience certificate in handling patients on dialysis.	☐	☐
iii.	Attested copy of Experience certificate	☐	☐

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13 b) Dialysis Technician-2

Name	Qualification	Yes	No
		☐	☐

Particulars and evidence of Dialysis Technician-2 provided as detailed below:

Name ☐ Date of Birth ☐

CNIC ☐ E-Mail ☐

Cell No. ☐

Residential Address ☐

Official Address ☐

		Submitted	*Not submitted*
i.	Attested copy of Diplomas / certificate of training in dialysis	☐	☐
ii.	Attested copy of experience certificate in handling patients on dialysis.	☐	☐
iii.	Attested copy of Experience certificate	☐	☐

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B) EQUIPMENT REQUIREMENT:

1 Laboratory Service:

	Availability (Certificate to be provided by the hospital)		**Functionality** (Certificate to be provided be the hospital)	
Hematology Cell Counter	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Chemistry Analyser	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Electrolyte Analyser	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Blood Gas Analyser	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Blood Bank Fridges 4.C	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
ELISA Plate reader and washer	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Dissection microscope	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Tissue processor, manual or preferably automated	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Tissue embedding center	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Microtome	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Cold Centrifuge	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Micro Centrifuge	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Microscope Fluorescent	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Microscopes	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Roller Mixers	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐
Automatic pipettes	Present ☐	Not Present ☐	Functionality ☐	Not Functionality ☐

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2) Radiology Department:

	Availability (Certificate to be provided by the hospital)		**Functionality** (Certificate to be provided be the hospital)	
	Present	Not Present	Functioning	Not Functioning
X-ray machine / Digital X-ray / Mobile X-ray	☐	☐	☐	☐
Doppler ultrasound machine with needle guide	☐	☐	☐	☐

***Disposables / Materials*:**

	Provided	Not Provided
Contrast material for IVP	☐	☐
Biopsy needle and gun	☐	☐
Sterilizing kits with gauze, pyodine, sterile gloves opsite, syringes	☐	☐
PCN / drainage packs.	☐	☐

3) Anesthesia Department:

	Availability (Certificate to be provided by the hospital)		**Functionality** (Certificate to be provided be the hospital)	
	Present	Not Present	Functioning	Not Functioning
Anesthesia machine and its affiliated functions (preferably with computerized ventilator) Machine with central supply of oxygen and oxygen cylinder Vaporizer (Cervoflurance, Isoflurane) Oxygen failure arm N2O cut of device Anti-hypoxic device	☐	☐	☐	☐
Ventilator (Digital or manual) with following features: Gas/ electric driven Tidal volume adjustment Ventilation mode adjustment Inspiratory / expiratory ratio Inspiratory flow rate	☐	☐	☐	☐

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Monitoring devices:	Present	Not present	Functioning	Not Functioning
ECG Pulse oximetery End Tidal CO_2 Non-invasive BP monitor Invasive BP monitor Temperature monitor (surface and Core)	☐	☐	☐	☐
Central venous pressure monitor Suction Machine	Present	Not present	Functioning	Not Functioning
	☐	☐	☐	☐

Warming Devices:	Present	Not present	Functioning	Not Functioning
Fluid warming cabinet Transfusion warmer Warming mattress Warming Blanket Worm air bler	☐	☐	☐	☐

***Disposables / Materials*:**

Airway management gadgets (laryngoscope, Bougie, Styllets, Endotracheal tubes, Laryngeal masks, Fiberoptic laryingo scope etc)	Provided ☐	Not Provided ☐
Reserve gas cylinders (O_2, N_2O, Air)	Provided ☐	Not Provided ☐
Infusion pumps	Provided ☐	Not Provided ☐
Syringe pumps	Provided ☐	Not Provided ☐
Nerve stimulators	Provided ☐	Not Provided ☐
CVP catheters (double and triple lumen)	Provided ☐	Not Provided ☐

4) Pharmacy Department:

The pharmacy must provide the following minimum requirements.

Disposables/ Materials:

IV anesthetic agents Thiopentone Propofol	Provided ☐	Not Provided ☐
Narcotics	Provided ☐	Not Provided ☐

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Non depolarizer muscle relaxants	Provided ☐	Not Provided ☐
Inotrops Dopamine Dobutamine Phenyl ephrine Adrenaline Nor epinephrine	Provided ☐	Not Provided ☐
Beta Blockers Inj. Labetalol Inderal)	Provided ☐	Not Provided ☐
Vasodilators GTN Hydralazine Nitro Prusside	Provided ☐	Not Provided ☐
Local anesthetic Bupivaccin Xylocaine	Provided ☐	Not Provided ☐
Naloxone	Provided ☐	Not Provided ☐
Calcium chloride	Provided ☐	Not Provided ☐
Mg SO_4	Provided ☐	Not Provided ☐
Immunosuppressive drugs.	Provided ☐	Not Provided ☐
Urine bags, Catheters	Provided ☐	Not Provided ☐
Hemodialysis and peritoneal dialysis, Catheters and solution	Provided ☐	Not Provided ☐
Anti-biotic, Anti-viral and Anti-fungal agents	Provided ☐	Not Provided ☐
Endotracheal tubes, Laryngeal masks, Central Venous Catheters	Provided ☐	Not Provided ☐
Dressings	Provided ☐	Not Provided ☐

5) Intensive Care Unit:

At least four bedded facility for 48 hours intensive care	Provided ☐	Not Provided ☐
Maneuverable bed equipped with facility for cardiac monitoring, invasive monitoring,	Provided ☐	Not Provided ☐
NIBP and Oximetry.	Provided ☐	Not Provided ☐
Stand by ventilator	Provided ☐	Not Provided ☐
Basic resuscitation trolley	Provided ☐	Not Provided ☐

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Complete in every respect as defined
in
Annexure……

6) Operation Theatre Department: Minimum Surgical Instrument required for renal transplantation.

i. Basic General Set for Operation Theatre	Provided ☐	Not Provided ☐
ii. Vascular Instruments for kidney Transplant:	Provided ☐	Not Provided ☐
Reynolds Scissors CVD 175 mm	Present ☐	Not Present ☐
Arteriotomy scissors Debakey CVD 175mm	Present ☐	Not Present ☐
Durotip Scissors 220mm CVD	Present ☐	Not Present ☐
NonTraumatic Vessel Forceps 150mm	Present ☐	Not Present ☐
Durogrip forceps 20 cm Slender Type	Present ☐	Not Present ☐
Durogrip Dissecting Forceps 180mm	Present ☐	Not Present ☐
Baby Mixture Forceps 140 mm	Present ☐	Not Present ☐
Jacobson Needle Holder W. Catch 185mm	Present ☐	Not Present ☐
Durogrip Debakey Needle holder 230mm	Present ☐	Not Present ☐
Durogrip Debakey Needle holder 250mm	Present ☐	Not Present ☐
Durogrip Needle Holder Ryder 155mm Delic	Present ☐	Not Present ☐
ATR Neonatal Miniature Forceps Small	Present ☐	Not Present ☐
ATR Neonatal Miniature Forceps Medium	Present ☐	Not Present ☐
ATR Neonatal Miniature Forceps Large	Present ☐	Not Present ☐
ATR Neonatal Miniature Forceps Clamp Curved	Present ☐	Not Present ☐
Non Traum Forceps cooley 90 Degree Small 165mm	Present ☐	Not Present ☐
De Bakey Buldog Clamp Curved 50mm	Present ☐	Not Present ☐

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A TR Buldog Clamp De Bakey CVD	Present ☐	Not Present ☐
A TR Buldog Clamp De Bakey CVD 23/78mm	Present ☐	Not Present ☐
A TR Buldog Clamp De Bakey CVD 31/86mm	Present ☐	Not Present ☐
A TR Buldog Clamp De Bakey CVD 42/97mm	Present ☐	Not Present ☐
Stanskey Vena-Cava Clamp Large	Present ☐	Not Present ☐
Stanskey Vena-Cava Clamp Medium	Present ☐	Not Present ☐
Stanskey Vena-Cava Clamp Large	Present ☐	Not Present ☐
Potts Scissors on Angle	Present ☐	Not Present ☐
Watson-Cheyon probe and Dissector	Present ☐	Not Present ☐
Omnai- Track Self Retaining Retactor (for vascular procedure)	Present ☐	Not Present ☐
Sterile Ice making Machine	Present ☐	Not Present ☐
De Bakey Buldog Clamp (Cross Action)	Present ☐	Not Present ☐

iii. For other requirements of operation theatre departments. Please see the section C of specialized services and facilities.

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C) SPECIALIZED SERVICES AND FACILITIES:

The hospital administrator will ensure satisfactory provision of the following services and facilities.

1) Laboratory Service:

The Hematology, Microbiology, Chemical Pathology and Histopathology Sections must be available and functional.

i.	**HEMATOLOGY: (Mandatory)**	Yes ☐	No ☐
	Routine Blood Counts / Peripheral films		
	Screening for sick cell / haemoglobino patients/ Malaria Parasites	Yes ☐	No ☐
ii.	**Microbiology:**	Yes ☐	No ☐
	Culture and Sensitivity		
iii.	**Chemical pathology: (Mandatory)**	Yes ☐	No ☐
	Biochemical Investigations		
	Organ Function Tests	Yes ☐	No ☐
	24 hours urinary analysis	Yes ☐	No ☐
iv.	**Histopathology:**	Provided ☐	Not Provided ☐
	Routine processing and reporting of biopsy		
	Cytology specimens process and reporting	Provided ☐	Not Provided ☐
v.	**Immunology:**	Provided ☐	Not Provided ☐
	Tissue typing		
	Immunosuppressive drug monitoring	Provided ☐	Not Provided ☐
	Molecular diagnostic facilities	Provided ☐	Not Provided ☐
	24 hours availability of laboratory	Yes ☐	No ☐

2) Operation Theatre And Anesthesia Department:

i.	Minimum two operating theatres	Provided ☐	Not Provided ☐
ii.	Separate theatre available for transplant procedures only	Provided ☐	Not Provided ☐
iii.	State of sterilization:	Provided ☐	Not Provided ☐
	Autoclave		
	Operating instructions	Provided ☐	Not Provided ☐
	Maintenance certificate	Provided ☐	Not Provided ☐
	Quality control on efficacy of sterilization	Provided ☐	Not Provided ☐

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iv.	SOPs of Operation Theatre	Provided ☐	Not Provided ☐
v.	Theatre personnel: Minimum of 6 trained staff Nurses	Provided ☐	Not Provided ☐
	Minimum of 4 Operation Theatre Assistants	Provided ☐	Not Provided ☐
	Minimum of 6 ancillary staff	Provided ☐	Not Provided ☐
vi.	Minimum of 2 electronically operated operation tables with high quality light devices	Provided ☐	Not Provided ☐
vii.	Minimum of 3 patient trolley	Provided ☐	Not Provided ☐
viii.	Patient lifting devices	Provided ☐	Not Provided ☐
ix.	Fridge / Freezer to produce ice	Provided ☐	Not Provided ☐
x.	Minimum of 4 bedded Recovery Room / High Dependency Unit, equipped with oxygen supply and monitoring devices.	Provided ☐	Not Provided ☐
xi.	Designated Scrub, changing and storage areas	Provided ☐	Not Provided ☐
xii.	Reception and rest areas	Provided ☐	Not Provided ☐
xiii.	Minimum of 2 Anesthetic rooms	Provided ☐	Not Provided ☐

3.) Pharmacy:

i.	Round the clock dedicated staff (with number) to respond to needs of transplant patients specially immunosuppression, antibiotics and other drugs.	Provided ☐	Not Provided ☐

4) Dialysis Facilities:

i.	Availability of portable Dialysis Machine for ICU	Provided ☐	Not Provided ☐
ii.	Minimum four Dialysis Machines in hospital	Provided ☐	Not Provided ☐
iii.	2 of 4 dialysis Machines reserved for hepatitis positive patients.	Provided ☐	Not Provided ☐
iv.	Water purification system (e.g. Reverse Osmosis etc)	Provided ☐	Not Provided ☐
v.	Monitoring facilities	Provided ☐	Not Provided ☐
vi.	Disposable and dialysis solutions	Provided ☐	Not Provided ☐

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6) Blood Bank:

Hospital should have blood bank facilities or proper arrangements with recognized blood bank with proper storage facility.

i.	Typing and cross matching tests	Yes ☐	No ☐
ii.	Blood storage facility	Yes ☐	No ☐
iii.	Cell separator	Yes ☐	No ☐
iv.	Ability to provide blood components	Yes ☐	No ☐

7) Record Keeping: According to Proforma provided

i.	Attach List of operations performed in the last 12 months	Provided ☐	Not Provided ☐
ii.	Attach List of dialysis performed in the last 12 months	Provided ☐	Not Provided ☐
iii.	Attach Record of morbidity mortality and audit meetings	Provided ☐	Not Provided ☐

8) Library and other Resources:

i.	Computers	Provided ☐	Not Provided ☐
ii.	Internet Access	Provided ☐	Not Provided ☐
iii.	24 hours availability of communication system, with power backup.	Provided ☐	Not Provided ☐
iv.	Public telephone systems	Provided ☐	Not Provided ☐
v.	Fax Machine	Provided ☐	Not Provided ☐
vi.	Photo-imaging machine	Provided ☐	Not Provided ☐
vii.	Advisory and committee room with 8-10 chairs (For patient related meeting)	Provided ☐	Not Provided ☐

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