Brain Death Declaration Form

We, the following members of the Board of medical experts after careful personal examination, hereby certify that Shri /Smt./Km_____ _____ aged about _____ S/o, D/o, W/o, Shri. _____ _____ resident of _____ _____ is dead on account of permanent and irreversible cessation of all functions of the brain-stem. The tests carried out by us and the findings therein are recorded in the Brain-Stem Death Certificate annexed hereto.

Dated _____ Signature_____

1. Medical Superintendent of the hospital
2. An independent Medical Practitioner nominated by the Medical Superintendent of the Hospital/AACT
3. A Neurologist or Neurosurgeon nominated by the Medical Superintendent of the Hospital/AACT
4. The doctor on-duty treating the patient

BRAIN-STEM DEATH CERTIFICATE

(A) Patient Details:

1. Name of the patient Shri/Smt./Km. _____

   S/o, D/o, W/o Shri_____

   Sex _____ Age _____

2. Home Address _____

   _____

   _____

3. Hospital Number _____

4. Name and Address of next of kin or person responsible for the patient (if none exists, this must be specified) _____

   _____

   _____

5. Has the patient or next of kin agreed to any transplant? _____

   _____

6. Is this a Police Case? Yes _____ No _____

(B) Pre-conditions:

1. Diagnosis : Did the patient suffer from any illness or accident that led to

irreversible brain damage? Specify details _____

_____

Date and time accident/onset of illness _____

Date and onset of non-responsible coma _____

2. Findings of Board of Medical Experts:
   (1) The following reversible causes of coma have been excluded:-
   Intoxication (Alcohol)
   Depression Drugs
   Relaxants (Neuromuscular blocking agents)

	First Medical Examination		Second Medical Examination	
	1st	2nd	1st	2nd
Primary hypothermia				
Hypovolaemic shock				
Metabolic or endocrine disorders				
Tests for absence of brain-stem functions				
(2) Coma				
(3) Cessation of spontaneous breathing				
(4) Pupillary size				
(5) Pupillary light reflexes				
(6) Doll's head eye movements				
(7) Corneal reflexes (Both sizes)				
(8) Motor response in any cranial nerve distribution, any responses to stimulation of face, limb, or trunk				
(9) Gag reflex				
(10) Cough (Tracheal)				
(11) Eye movements on coloric testing bilaterally				
(12) Apnoea tests as specified				
(13) Were any respiratory movements seen?				
Date and time of first testing				
Date and time of second testing				

This is to certify that the patient has been carefully examined twice after an interval of about six hours and on the basis of findings recorded above, Shri./Smt./Km. _____ is declared brain-stem dead.

Signature_____

1. Medical Administrator Incharge of the hospital.
2. Authorized Specialist.
3. Neurologist/Neurosurgeon
4. Medical Officer treating the patient.

NB: I. The minimum time interval between the first testing and second testing will be six hours.

II. No.2 and No.3 will be co-opted by the Administrator Incharge of the hospital from the Panel of experts by the appropriate authority.