SOTTO TELANGANA (JEEVANDAN)

**Deceased Donor Organ Transplantation Programme, Government of Telangana**
**Comprehensive Patient Registration & Medical Evaluation Form**

Patient photo

Date: _____Hospital_____

## SECTION A: Patient Demographic Information

| | | |
|---|---|---|
| **Patient Name*:** | **Surname *:** | **Gender*:** □ Male □ Female □ Other |
| **Date of Birth:*** / / | **Age (Years):** | **Organ:** * |
| **Father's Name:** | **Mother's Name:** | **Spouse Name:** |
| **Marital Status:** □ Single □ Married □ Widow(er) □ Divorced | **Marriage Date:** / / | **Children:** |
| **Qualification / Education:** | **Occupation / Designation:** | **Annual Income (₹):** |
| **Religion / Caste / Community:** | **Nationality:** Indian | **Citizen:** □ Indian □ NRI □ Foreigner |
| **Email ID:** | **State:** * | **District:** |
| **Present Address:*** | **Permanent Address:** | |
| **Emergency Contact Person:** * | **Relation:** | **Alternative Number:** |
| **Aadhar Number:*** | **ABHA Number:** | **Blood Grouping and typing** * |
| **Aarogya Sri Number:*** | **Hospital Registration Number (OP/IP/CR):*** | |
| **Previous Kidney Donor:** * □ Yes / □ No, if Yes (Dt:_____) | **Graft Failure:** * □ Yes □ No, if Yes (Dt:_____) | **Fistula Failure:** * □ Yes/ □ No, if Yes(_____) |
| **Near Relative of a Deceased donor:** * □ Yes / □ No | **Synthetic Graft Failure:** * □ Yes / □ No | **Date of 1st Dialysis date:** * |

## SECTION B: FAMILY DETAILS & ORGAN PLEDGING - Total Family Members Pledged: _____

| Relationship | Name | Age | Occupation | Contact | Aadhar Number | Pledge Y/N |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## SECTION C: PHYSICAL & GENERAL HEALTH PARAMETERS

| Parameter | Details | Parameter | Details |
|---|---|---|---|
| Height (cm) | | Weight (kg) / BMI | / |
| Diabetes Mellitus (DM) | □ Yes / □ No | Hypertension (HTN) | □ Yes / □ No |
| Cardiac Disease | □ Yes / □ No | Liver Disease | □ Yes / □ No |
| Lung Disease | □ Yes / □ No | Neurological Disease | □ Yes / □ No |
| Tuberculosis | □ Yes / □ No | HIV / HBsAg / HCV Status | |
| Allergies (Drugs / Food / Others) | | Surgeries Done (if any) | □ Yes / □ No |
| No of Blood transfusions | | Past History of malignancy | |
| Family history of kidney diseases | | Family History of Chronic Diseases | □ Yes / □ No |
| Smoking | □ Yes / □ No | Alcoholism | □ Yes / □ No |
| Drug abuse | | Psychiatric illness | |

## SECTION D: FEMALE PATIENTS – PREGNANCY & REPRODUCTIVE HISTORY

| Parameter | Details | | |
|---|---|---|---|
| Menstrual Cycle | □ Regular / □ Irregular | No. of Pregnancies (Gravida) | |
| No. of Live Births (Para) | | Abortions / Miscarriages | |
| Last Pregnancy Date | | Complications | |

**SECTION E: TRAVEL DISTANCE, ACCESSIBILITY & USEFULNESS FOR TRANSPLANT CARE**

| Parameter | Details | | |
|---|---|---|---|
| Current Place of Residence (Village/Town/District) | | Average Travel Time | |
| Distance from Registered Hospital (Approx. km) | | Remarks on Travel | |
| Travel Feasibility for Emergency Transplant Call | □ Feasible □ Difficult | Mode of Transport | □ Ambulance / □ Private Vehicle/ □ Public Transport |

**SECTION F: BIOPSY DETAILS -** □ Done □ Not

| | | | |
|---|---|---|---|
| Date / Lab no | | Renal Biopsy Report details | |
| Hospital Name | | LM | |
| IF | | Remarks | |

**SECTION G: DIAGNOSIS DETAILS: Primary Diagnosis**: _____

| Category | Details | | |
|---|---|---|---|
| **Comorbidities** | 1.<br>2.<br>3.<br>4. | **Complications** | 1.<br>2.<br>3.<br>4. |

**SECTION H: DIALYSIS DETAILS**

| S. No | Hospital Name | District | From | To | Duration | Type (HD/PD) | Remarks |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |

**SECTION I: ACCESS DETAILS -** □ Yes □ No, Number of Access Failures: _____

| S. No | Type of Access | Failure (Y/N) | Date of Creation | Hospital | District | Site | Remarks |
|---|---|---|---|---|---|---|---|
| 1 | AV Fistula 1 | □ Yes / □ No | | | | | |
| | 2 | □ Yes / □ No | | | | | |
| | 3 | □ Yes / □ No | | | | | |
| | 4 | □ Yes / □ No | | | | | |
| 2 | AV Graft / Permcath | □ Yes / □ No | | | | | |
| 3 | Synthetic Graft Failure | □ Yes / □ No | | | | | |

**SECTION J: PREVIOUS KIDNEY DONOR:** □ Yes / □ No

| Parameter | Details | | |
|---|---|---|---|
| Date of Donation | | Donated to Whom | |
| Donated Left / Right Kidney | | Donated Hospital Name | |

**SECTION K: PREVIOUS KIDNEY TRANSPLANT & GRAFT FAILURE HISTORY:** □ Yes / □ No

| Parameter | Details | | |
|---|---|---|---|
| Transplanted from | □ Living / □ Deceased | Date of Transplant | |
| Graft Failure Date & Relation | / | Transplanted Hospital Name | |
| Hospital Address | | Reason for Failure | |

**SECTION L: AAROGYASRI / DD details:**

| Field | Details | | |
|---|---|---|---|
| Hospital Type | □ Government / □ Private | Aarogyasri Registration Eligible only for Govt | □ Yes / □ No |
| **If Yes**: Aarogya Sri Card Number | | Aarogyasri Holder: | |
| **DD DETAILS** *(*Not required for Aarogya Sri Patients registering at Govt. Hospitals for registration payment)* | | | |
| DD Number | | DD Date | |
| Amount (₹) | | Bank Name | |
| Issuing Branch | | Date of DD | |

## SECTION M: IMPORTANT INFORMATION FOR ORGAN TRANSPLANT RECIPIENTS

### THOTA ACT, 1994 – SUMMARY / థోటా చట్టం, 1994 – సారాంశం

The SOTTO Telangana functions under the **Transplantation of Human Organs and Tissues Act (THOTA), 1994**.
తెలంగాణలో అవయవ మార్పిడి కార్యక్రమం (SOTTO) **THOTA Act, 1994** ప్రకారం అమలులో ఉంది.

All transplant recipients must understand the following: అన్ని రోగులు క్రింది అంశాలను అర్థం చేసుకోవాలి:

- **Brain Death:** Recognized as legal death for organ donation.
  **బ్రెయిన్ డెత్:** అవయవ దానం కోసం చట్టపరమైన మరణంగా గుర్తించబడుతుంది.
- **Consent:** Mandatory consent must be obtained from the **donor (in case of prior pledge)** or **next-of-kin after brain death**.
  **సమ్మతి:** దాత ముందుగా అంగీకారం (pledge) ఇచ్చి ఉంటే దాని ప్రకారం, లేకపోతే **బ్రెయిన్ డెత్ తరువాత కుటుంబ సభ్యుల నుండి అనుమతి తప్పనిసరి**.
- **No Commercialisation:** Buying/selling organs is punishable.
  **వ్యాపారం నిషేధం:** అవయవాల కొనుగోలు/అమ్మకం చట్టరీత్యా శిక్షార్హం.
- **Authorization Committee:** Approval required for living donor transplantation.
  **ఆథరైజేషన్ కమిటీ:** లైవ్ డోనర్ ట్రాన్స్‌ప్లాంట్‌కు అనుమతి అవసరం.
- **Registered Hospitals Only:** Transplantation can be done only in authorized hospitals.
  **గుర్తింపు పొందిన ఆసుపత్రులు మాత్రమే:** అధికారిక ఆసుపత్రుల్లోనే మార్పిడి జరగాలి.
- **Recipient Responsibility:** Regular follow-up and timely updates are mandatory.
  **రోగి బాధ్యత:** రెగ్యులర్ ఫాలోఅప్ మరియు వివరాల నవీకరణ తప్పనిసరి.

This Act ensures transparency, ethics, and equitable organ allocation. ఈ చట్టం పారదర్శకత, నైతికత మరియు సమానత్వాన్ని నిర్ధారిస్తుంది.

## SECTION N: CONSENT & AWARENESS DETAILS FOR PATIENTS

| Question | Yes / No Details if any , Remarks | | |
|---|---|---|---|
| Informed about THOTA Act provisions & Donation Process | □ Yes / □ No | Aware of importance of Organ Donation | □ Yes / □ No |
| Willing to Campaign for Organ Donation | □ Yes / □ No | Willing to motivate family/friends | □ Yes / □ No |
| Follows-up regularly with the hospital | □ Yes / □ No | Informed to update address/phone/others | □ Yes / □ No |

## SECTION O: DATA SHARING CONSENT & DECLARATION

I, _____, hereby consent to share my personal and medical data with SOTTO Telangana as per the **THOTA Act, 1994** for organ allocation and monitoring.

I declare that the above information is true and I will follow all SOTTO norms. I will update any changes in my contact details, hospital, or dialysis status and maintain regular follow-up. I understand that my registration may be kept **"on hold"** if there is no follow-up for 6 months.

I also confirm that I have understood THOTA guidelines and will not engage in any organ buying or selling.

**Name & Signature of Patient**: _____**Date**:_____

**Family Attendant Name & Signature**: _____**Relation**_____

## SECTION P: LIVE DONATION EVALUATION & REASON FOR REGISTRATION UNDER SOTTO

(To assess whether living donor transplantation was attempted before applying under Deceased Donor Waitlist)

*Was Living Donor Transplantation Attempted?* : □ Yes / □ No, **If No, Reason**: _____

**Type of Living Donation Attempted**

| | | | | | |
|---|---|---|---|---|---|
| 1st Degree Relative Donation | □ | 2nd Degree Relative Donation | □ | Swap Transplantation | □ |

A. 1st Degree Relatives

| Relation | Name(s) | Evaluated | Compatible | Willing to Donate | Reason for Not Donating |
|---|---|---|---|---|---|
| Spouse | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Father | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Mother | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Son 1 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Son 2 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Daughter 1 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Daughter 1 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Brother 1 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Brother 2 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Sister 1 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Sister 2 | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |

B. 2nd Degree Relatives

| Relation | Name(s) | Evaluated | Compatible | Willing to Donate | Reason for Not Donating |
|---|---|---|---|---|---|
| Grandparents | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Uncle / Aunt | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Nephew / Niece | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Cousins | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |
| Other Relatives | | □ Yes / □ No | □ Yes / □ No | □ Yes / □ No | |

Reason for Applying under SOTTO (Deceased Donor Waitlist): _____

## SECTION Q: Clearances

| | | | |
|---|---|---|---|
| **Cardiology & Date:** | | **Pulmonology & Date:** | |
| **Medical Gastroenterology & Date:** | | **Gynaecology:* Female & Date:** | |
| **Psychiatry & Date:** | | **Urology & Date:** | |
| **Nephrology & Date:** | | **Others & Date:** | |

## IMPORTANT NOTE

- This application is strictly for **Deceased Donor Kidney Transplantation Registration** only under **SOTTO Telangana**.
- All details entered in this Medical Evaluation Form and all supporting documents uploaded must be **complete, accurate, and duly verified** by the **Treating, Surgeon Team**, **Transplant Coordinator and the Registered Hospital**.
- The **hospital and transplant coordinator shall be fully responsible** for correctness of the data, documents, and clinical information submitted.
- Any **incorrect / incomplete / mismatched information** or **submission of false documents** will be viewed seriously and may lead to **rejection/decline of registration** and further action as per applicable rules.

## SECTION R: VERIFICATION & APPROVAL

**Treating Doctor**

Signature & Stamp: _____
Name: _____
Designation: _____

**Transplant Surgeon**

Signature & Stamp: _____
Name: _____
Designation: _____

**Hospital Admin**

Signature & Stamp: _____
Name: _____
Designation: _____

**CHECK LIST FOR KIDNEY REGISTRATION (DECEASED DONOR WAITLIST) @ Transplant Coordinator**

**Patient Name: _____Age_____ Gender_____ Blood Group_____ Hospital Name: _____**

**1st Part Registration: BASIC PATIENT DETAILS**

| Sl. No | Document | Updated in Portal |
|---|---|---|
| 1 | Recent Passport Size Photograph (Clear) | □ Yes / □ No |
| 2 | Aadhaar Card | □ Yes / □ No |
| 3 | Blood Group Report (Hospital/Lab Certified) | □ Yes / □ No |
| 4 | Valid Residence Proof (MRO Certificate / Ration Card / Passport/ Driving License) | □ Yes / □ No |

**2nd Part Registration: MEDICAL DOCUMENTS for Dialysis**

| Sl. No | Document | Details | Updated in Portal |
|---|---|---|---|
| 1 | **Medical Fact Form** (Complete & Signed) | Medical Fact Date: | □ Yes / □ No |
| 2 | **Treating Doctor Letter** (With Dialysis Start) | Date: | □ Yes / □ No |
| 3 | **First Dialysis** Summary with Sign & Stamp | Date: | □ Yes / □ No |
| 4 | **Dialysis Continuation Proof** (Monthly Bills **/** Dialysis Book with last page Sign & Stamp **/** Aarogyasri M6.5 Summary) | Monthly updated till: | □ Yes / □ No |
| 5 | **Hepatitis B** Report | Positive / Negative | □ Yes / □ No |
| 6 | **Hepatitis C** Report | Positive / Negative | □ Yes / □ No |

**FAILURE / TRANSPLANT HISTORY**

| Sl. No | Category | Status (Yes/No) | Key Dates | Updated in Portal |
|---|---|---|---|---|
| 1 | Fistula Failure | □ Yes / □ No | Number of Failure: Date: | □ Yes / □ No |
| 2 | Previous Kidney Donor | □ Yes / □ No | Donation Date: | □ Yes / □ No |
| 3 | Previous Kidney Transplant | □ Yes / □ No | Transplant Date: | □ Yes / □ No |
| 4 | Graft Failure | □ Yes / □ No | Failure Date: | □ Yes / □ No |
| 5 | Synthetic Graft Failure | □ Yes / □ No | Failure Date: | □ Yes / □ No |
| 6 | Biopsy | □ Yes / □ No | Date: | □ Yes / □ No |
| 7 | Cardiology | Date: | | □ Yes / □ No |
| 8 | Pulmonology | Date: | | □ Yes / □ No |
| 9 | Medical Gastroenterology | Date: | | □ Yes / □ No |
| 10 | Psychiatry | Date: | | □ Yes / □ No |
| 11 | Urology | Date: | | □ Yes / □ No |
| 12 | Gynaecology (if Female) | Date: | | □ Yes / □ No |

**FINAL VERIFICATION**

I hereby certify that: All details entered in the Medical Fact Form are **true and verified**

- All documents are **uploaded in portal @** clear, legible, and consistent**:** □ Yes / □ No
- All dates are **clearly mentioned:** □ Yes / □ No
- All "Yes" cases have **supporting documents uploaded:** □ Yes / □ No
- Data is **consistent and verified:** □ Yes / □ No

**Transplant Coordinator Details @ Registering the Patient in Portal**

**Name: _____Hospital:_____Signature: _____Date:_____**