



SOTTO TELANGANA
Deceased Donor Organ Transplantation Programme
Government of Telangana
Comprehensive Patient Registration & Medical Evaluation Form



SECTION A: Patient Demographic Information

Patient Name:		Surname:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Date of Birth:* / /		Age (Years):	Organ -
Father's Name:		Mother's Name:	Spouse Name:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced		Marriage Date: / /	Children:
Qualification / Education:		Occupation / Designation:	Annual Income (₹):
Religion / Caste / Community:		Nationality: Indian	Citizen: <input type="checkbox"/> Indian <input type="checkbox"/> NRI <input type="checkbox"/> Foreigner
Email ID:		State:	District:
Present Address:*			
Permanent Address:			
Emergency Contact Person:		Relation:	Contact Number:
Native state if not from Telangana			
ABHA Number:*		Aadhar Number:*	
Aarogya Sri Number:*		Hospital Registration Number (OP/IP/CR):*	
Phone Number:		Alternate Number:	
Blood Grouping and typing *			
Previous Donor for Living related transplant *			
Near Relative of a Deceased donor *			

SECTION B: FAMILY DETAILS & ORGAN PLEDGING

Total Family Members Pledged: _____

Relationship	Name	Age	Occupation	Contact	Aadhar No	Pledge Y/N
Father						
Mother						
Spouse						
Son/Daughter						
Brother/Sister						
Other Relatives						

SECTION C: CONSENT & AWARENESS DETAILS

Question	Yes / No Details if any , Remarks
Informed about THOTA Act provisions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Informed about Deceased Organ Donation process	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aware of importance of Organ Donation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Willing to Campaign for Organ Donation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Willing to motivate family/friends	<input type="checkbox"/> Yes <input type="checkbox"/> No
Agrees to share medical data for matching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Understands organ allocation norms	<input type="checkbox"/> Yes <input type="checkbox"/> No
Follows-up regularly with the hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No
Informed to update address/phone	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION D: DATA SHARING CONSENT & DECLARATION

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

I declare that the above information is true to the best of knowledge and I will follow all SOTTO norms. I will inform SOTTO about any changes in contact, hospital, or dialysis details. I will follow-up with the registered hospital regularly. I realise that my registration will be "on hold" if the communication / follow-up with the registered hospital is not done for a continuous period of 6 months.

Signature of Patient: _____
 Date: _____
 Contact: _____

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

SECTION E: PHYSICAL & GENERAL HEALTH PARAMETERS

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

SECTION F: PREVIOUS TRANSPLANT HISTORY

	Details
Previous Organ Transplantation (Yes/No)	
Type of Organ	
Date of Transplant	
Donor Details	
Hospital Name	
Graft Failure (Yes/No)	
If Yes, Date of Failure	
Reason for Failure	
Any Re-Transplant Planned	

SECTION G: FEMALE PATIENTS – PREGNANCY & REPRODUCTIVE HISTORY

Parameter	Details
Menstrual Cycle	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular
No. of Pregnancies (Gravida)	
No. of Live Births (Para)	
Abortions / Miscarriages	
Last Pregnancy Date	
Complications	

SECTION H: LIVE DONATION STATUS & SOTTO REGISTRATION REASON

Question	Response
Any Family Member Evaluated for Live Donation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Relation	
Organ Matched?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Live Donation Attempted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason Live Donation Not Done	<input type="checkbox"/> Medical Unfit <input type="checkbox"/> Blood Group Mismatch <input type="checkbox"/> Donor Withdrawn <input type="checkbox"/> Family Unwilling <input type="checkbox"/> Financial Constraints <input type="checkbox"/> Other
Who Suggested Registration under SOTTO	
Rejection / Non-Compatibility Details	
Reason for Applying under Deceased Donor Waitlist	

SECTION I: AROGYASRI / INSURANCE details

Field	Details
Hospital Type	<input type="checkbox"/> Government <input type="checkbox"/> Private
Eligible under Aarogyasri (Transplant)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes: Aarogya Sri Card Number	
Insurance Scheme Name	
Valid From	
Valid To	
Insurance / EHS / CGHS Number	
Private Insurance Details	

DD DETAILS (*Not required for Aarogya Sri Patients registering at Govt. Hospitals for registration payment)

Field	Details
DD Number	
DD Date	
Amount (₹)	
Bank Name	
Issuing Branch	
Date of Submission	

SECTION J: TRAVEL DISTANCE, ACCESSIBILITY & USEFULNESS FOR TRANSPLANT CARE

Parameter	Details
Current Place of Residence (Village/Town/District)	
Registered Transplant Hospital	
Distance from Residence to Transplant Hospital (Approx. km)	
Average Travel Time (One Way)	
Mode of Transport	<input type="checkbox"/> Ambulance <input type="checkbox"/> Private Vehicle <input type="checkbox"/> Public Transport
Frequency of Travel Required	<input type="checkbox"/> Dialysis <input type="checkbox"/> OP Follow-up <input type="checkbox"/> Admission
Travel Feasibility for Emergency Transplant Call	<input type="checkbox"/> Feasible <input type="checkbox"/> Difficult
Usefulness of Proximity for Timely Kidney Transplantation	<input type="checkbox"/> Very Useful <input type="checkbox"/> Moderately Useful <input type="checkbox"/> Limited
Patient/Family Remarks on Travel & Accessibility	

Clearance/ Report	
Cardiology:	
Pulmonology:	
Medical Gastroenterology:	
Gynaecology:* Female	
Psychiatry	
Urology:	
Others	

SECTION K: DIAGNOSIS DETAILS

Category	Details
Primary Diagnosis	
Comorbidities	1. 2. 3. 4.
Complications	1. 2. 3. 4.

SECTION L: BIOPSY DETAILS

Date / lab no	
Renal Biopsy Report	
Hospital	
LM	
IF	
Remarks	

SECTION M: DIALYSIS DETAILS

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

SECTION N: ACCESS DETAILS

No. of Access Failures: _____

S. No	Type of Access	Site	Date of Creation	Hospital	District	Failure (Y/N)	Remarks
1	AV Fistula 1					<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2					<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3					<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4					<input type="checkbox"/> Yes <input type="checkbox"/> No	
2	AV Graft / Permcath					<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION O: VERIFICATION & APPROVAL**FITNESS FOR TRANSPLANTATION****Treating Doctor**

Name: _____
 Designation: _____
 Signature: _____

Transplant Surgeon

Name: _____
 Designation: _____
 Signature: _____

Hospital Admin Doctor

Name: _____
 Designation: _____
 Signature: _____

SECTION P: IMPORTANT INFORMATION FOR ORGAN TRANSPLANT RECIPIENTS

- The Organ Transplant Programme in Telangana (SOTTO **Legal Basis:** Governs organ donation & transplantation in India.
- **Brain Death:** Recognized for organ retrieval.
- **Consent:** Required from donor or next-of-kin.
- **No Commercialisation:** Buying/selling organs is a criminal offence.
- **Authorization Committee:** Approves live donations.
- **Hospital Requirements:** Only registered hospitals can retrieve or transplant organs.
- **Recipient Responsibility:** Must follow protocol, update contact information, and not engage in illegal activities.

This Act ensures a transparent, ethical, and equitable organ allocation system.
All transplant recipients are required to carefully read and understand the following important provisions:

THOTA ACT, 1994 – SUMMARY

Key Provisions

THOTA ACT, 1994– SUMMARY

- THOTA చట్టం (1994) అనేది మన శరీర అవయవాల దానం మరియు మార్పిడి నిర్వహణకు భారతదేశంలో అమలులో ఉన్న ప్రధాన చట్టం.
- బ్రెయిన్ డెత్ ను ఈ చట్టం ప్రకారం చట్టపరంగా మరణంగా అంగీకరిస్తారు.
- అవయవం దానం చేయడానికి దాత (డోనర్) లేదా సన్నిహిత బంధువుల సమ్మతి (కనెంట్) తప్పనిసరి.
- అవయవాల కొనుగోలు - అమ్మకం చేయడం చట్టవిరుద్ధం, దానికి జైలుశిక్ష/ చట్టపరమైన చర్యలు తప్పవు.
- లైఫ్ నేషన్ (జీవించి ఉన్న వ్యక్తి అవయవం) కోసం ఆధరైజేషన్ గుమిటీ ఆమోదం అవసరం.
- అవయవాల ట్రాన్స్ ప్లాంట్ ప్రభుత్వం నమోదు చేసిన ఆసుపత్రులలో మాత్రమే జరగాలి.

రోగి బాధ్యతలు:

- ప్రభుత్వ నిబంధనలు, మార్గదర్శకాలు పాటించడం.
- అక్రమ అవయవాల దానం దేవీలలో పాల్గొనకూడదు - ఇలాంటి చర్యలు చేస్తే రిజిస్ట్రేషన్ రద్దు అవుతుంది
- చిరునామా లేదా ఫోన్ నెంబర్ మార్చితే వెంటనే SOTTO కి సమాచారం ఇవ్వాలి

Recipient Undertaking

I, _____, hereby confirm that I have understood THOTA guidelines and agree not to engage in buying/selling of organs.

Signature: _____

Date: _____