NATIONAL TRANSPLANT PROCUREMENT MANAGEMENT UNIT
Donor Referral Form

019-3885654 (on call)	03-26942704 / 05 (HKL) 03-26810681 / 82 (Wisma Sejarah)	03-26155555 EXT 6576	739444 (Pager)	03-26156269 (fax) - (HKL) 03-26810680 (fax)- (Wisma Sejarah)

Instruction: Where check boxes ☐ are provided, check (√) one or more boxes. Where radio buttons ◉ are provided, check (√) one box only.

i. Centre Code: ☐☐☐☐ **Or Reporting centre name:** _____

ii.* Date & Time of referral: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) **Time:** ☐☐☐☐ (24 hrs clock) **iii.* Status:** ◉ Suspected Brain Death ◉ Cardiopulmonary death

SECTION 1 - 11 DONOR INFORMATION

SECTION 1 : DONOR DETAILS & DEMOGRAPHICS

1. Name : *
(Please write in capital letters)

2. NRIC : *
MyKad / MyKid: ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC: ☐☐☐☐☐☐☐☐☐☐

Other ID document No: _____

Specify document type (if others):
◉ Army ◉ Police ◉ Mother's IC ◉ Father's IC ◉ Work Permit ◉ Passport ◉ Birth Certificate ◉ Pension Card ◉ Others: _____

3. Address:

Postcode: ☐☐☐☐☐ Town / City: _____

State :
◉ Johor Darul Takzim ◉ Kedah Darul Aman ◉ Kelantan Darul Naim ◉ Melaka ◉ Negeri Sembilan Darul Khusus
◉ Pahang Darul Makmur ◉ Perak Darul Ridzuan ◉ Perlis Indera Kayangan ◉ Pulau Pinang ◉ Sabah
◉ Sarawak ◉ Selangor Darul Ehsan ◉ Terengganu Darul Iman ◉ Wilayah Persekutuan Kuala Lumpur
◉ Wilayah Persekutuan Labuan ◉ Wilayah Persekutuan Putrajaya ◉ Not applicable - Foreign

4. Date of Birth: *
(dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ ☐ Estimated / presumed year (autofill if MyKad is available)
If the exact date is not known, please enter 01/07/yyyy & check the estimated/presumed year box

5. Age at Referral: (autocalculate) ☐☐☐ years(s) ☐☐ month(s) ☐☐ day(s)

6. Gender: *
◉ Male ◉ Female

7. Ethnic group: *
◉ Malay ◉ Chinese ◉ Indian ◉ Bumiputera Sabah, specify _____ ◉ Bumiputera Sarawak, specify _____ ◉ Orang Asli ◉ Others: _____

8. Religion: *
◉ No Information ◉ Islam ◉ Christianity ◉ Buddhism ◉ Hinduism ◉ Sikhism ◉ Atheist ◉ Taoism ◉ Confucianism ◉ Bahaism ◉ Animism ◉ Others : _____

9. Nationality:
◉ Malaysian ◉ Permanent Resident ◉ Non-Malaysian, specify country: _____

SECTION 2 : EDUCATION LEVEL, MARITAL STATUS & OCCUPATION

1. Education level :
◉ Primary ◉ Secondary ◉ Tertiary ◉ Nil ◉ Unknown

2. Marital status:
◉ Single ◉ Married ◉ Widowed ◉ Divorced ◉ Unknown

3. Occupation:
◉ Legislator senior officals, managers
◉ Technicians, associate professionals
◉ Service workers, shop and market sales workers
◉ Craft and related trades workers
◉ Student
◉ Elementary occupations
◉ Health Professionals
◉ Other professionals
◉ Clerical workers
◉ Skilled agricultural, fishery workers
◉ Plant and machine operators and assemblers
◉ Housewife
◉ Others, specify _____
◉ Unemployed
◉ Retired
◉ Unknown

SECTION 3 : HEIGHT & WEIGHT

1. Height: (cm) ☐☐☐.☐ **2. Weight:** (kg) ☐☐☐.☐ **3. BMI:** (kg /m^2) ☐☐☐.☐☐ *(Autocalculate)*

SECTION 4 : BLOOD GROUP & RHESUS *(Not applicable for Cardiopulmonary Death)*

1. Blood group
◉ A ◉ B ◉ AB ◉ O

2. Rhesus
◉ Positive ◉ Negative

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SECTION 5 : HOSPITAL ADMISSION DETAILS

1. Location where donor was referred from:
◯ Hospital → ◯ ICU ◯ Ward ◯ Emergency department ◯ Mortuary ◯ Others, specify : _____
◯ Home (Please complete no 9 onwards, No 2 to 8 are not applicable) ◯ Others, specify : _____

2. Hospital Name: **Code:** ____ _____ **3. R/N :** _____

4. Ward: _____ **5. Primary Unit:** ◯ Surgical ◯ Neuro Surgical ◯ Orthopaedic ◯ Obstetrical & Gynaecological ◯ Medical ◯ Neuro Medical ◯ Paediatric ◯ Others, specify: _____

6. Hospital admission date & time: __ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock)

7. Intubation date & time: __ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock) **8. ICU admission date & time:** __ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock)

9. Diagnosis: _____

10. Referred by:
◯ By primary doctor
◯ Identified by TOP team
◯ ICU / Ward staff
→ **a. Name:** _____
◯ Initiated by family ◯ Others, specify : _____
ADD

SECTION 6 : TRAUMA & SURGERY

1. Trauma? ◯ Yes → ◯ No
☐ Head injury ☐ Abdomen injury ☐ Eye injury ☐ Others, specify: _____
☐ Chest injury ☐ Skin abrasion ☐ Polyfracture

2. Surgery performed? ◯ Yes → ◯ No

a) Type of surgery	b) Date of surgery (dd/mm/yyyy)	a) Type of surgery	b) Date of surgery (dd/mm/yyyy)
☐ Intracranial surgery	__ / __ / ____	☐ Orthopaedic surgery	__ / __ / ____
☐ Chest surgery	__ / __ / ____	☐ Others, specify: _____	__ / __ / ____
☐ Abdomen surgery	__ / __ / ____		

ADD

3. Date & time seen by TOP team: __ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock)

SECTION 7 : BRAIN DEATH *(Not applicable for Cardiopulmonary Death)*

1. Fullfill criteria for brain death? ◯ Yes → ◯ No

1a) Off muscle relaxant: __ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock) **1b) Off sedation:** __ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock)

1c) Type of sedation: ☐ Morphine ☐ Propofol ☐ Midazolam ☐ Others, specify: _____

SECTION 8 : DECLARATION OF BRAIN DEATH (Not applicable for Cardiopulmonary Death)

1. Brain Death test done?
◯ Yes
◯ No
◯ Not completed
→ Reason: * ◯ Patient is not brain dead ◯ No clearance from primary doctor ◯ No clearance from family ◯ Unable to correct parameters for brain death diagnosis ◯ Proceeded to cardiac death before test can be done ◯ Others, specify : _____

2. 1st brain death test:	**2a. Doctor A:**	**i. Name:**	**ii. Designation:**	
	2b. Doctor B:	**i. Name:**	**ii. Designation:**	
	2c. Date & Time:	__ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock)		
3. 2nd brain death test:	**3a. Doctor A / C:**	**i. Name:**	**ii. Designation:**	☐ Same as above
	3b. Doctor B / D:	**i. Name:**	**ii. Designation:**	☐ Same as above
	3c. Date & Time:	__ / __ / ____ (dd/mm/yyyy) **Time:** ____ (24 hrs clock)		

4. Was instrumental test done : ◯ Yes → ☐ Cerebral angiography ☐ Perfusion Scan ☐ EEG ☐ Others, specify: _____
◯ No

☐ Death Confirmed

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SECTION 9 : DEATH DETAILS

1. Date & Time * death confirmed: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) **Time:** ☐☐☐☐ (24 hrs clock)

2. Cause of death * / significant events:

◯ Brain death

- ☐ Traumatic head injury
  - ☐ Road traffic accident
  - ☐ Industrial accident
  - ☐ Others, specify _____
  - ☐ Fall
  - ☐ Homicide
  - ☐ Suicide
- ☐ Spontaneous intracranial hemorrhage
  - Specify:
- ☐ Thromboembolic brain infarct
- ☐ Brain hypoxic encephalopathy
- ☐ Others, specify:
- ☐ Intracranial tumors
- ☐ Intracranial infection
- ☐ Pending Post Mortem

◯ Cardiopulmonary death

- ☐ Traumatic injury
  - ☐ Road traffic accident
  - ☐ Industrial accident
  - ☐ Others, specify _____
  - ☐ Fall
  - ☐ Homicide
  - ☐ Suicide
- ☐ Heart disease
- ☐ Endocrine disease
- ☐ Cancers
- ☐ Respiratory disease
- ☐ Infection
- ☐ Poisoning
- ☐ Others, specify:
- ☐ Pending Post Mortem

3. Donation initiated by:

- ◯ Transplant coordinator
- ◯ Ward doctor
- ◯ TOP team member on rounds

→ **a. Name:**

- ◯ Family
- ◯ Others, specify : _____

SECTION 10 : CONSENT FOR ORGAN & TISSUE DONATION

1. Was the donor registered pledger?

◯ Yes ◯ No

2. Was request for organ / tissue donation made? (Primary reason)

◯ Yes

- i. Person who made the initial request: ◯ Ward doctor ◯ Transplant coordinator ◯ Others, specify: _____ ◯ Family initiated ◯ TOP team
- ii. Name:

◯ No

- i. Reason for not making the request:
  - ◯ No clearance from primary doctor
  - ◯ No medical legal clearance
  - ◯ Family did not accept brain death
  - ◯ Donor not suitable
    - ☐ Having transmissible disease
    - ☐ Non accepatable cancer
    - ☐ Overwhelming sepsis
    - ☐ Multiorgan failure
    - ☐ High risk activities
    - ☐ Not brain dead
  - ◯ Staff uncomfortable about making the request
  - ◯ Unable to contact family
  - ◯ Others, specify : _____

3. Has the family and the deceased ever discussed about donation before?

◯ Yes ◯ No

4. Was organ/ tissue donation request outcome successful?

* ◯ Yes

- ◯ Unconditional consent ◯ Conditional consent, specify _____

◯ No *(Section 9 : no.5, 6. 7 & Section 12 - 30 are not required)*

Reason:-

◯ Direct refusal ◯ Others, specify: _____

- i. Reason for direct refusal:
  - ☐ Family did not accept death - not convinced about brain death
  - ☐ Perceived as against religious beliefs
  - ☐ Family did not know the wishes of the deceased
  - ☐ No consensus / differing opinion among family members
  - ☐ Others, specify : _____
  - ☐ Concern about mutilation
  - ☐ Concern about funeral delay
  - ☐ Did not want deceased to suffer anymore
  - ☐ Intervention by 3rd party
  - ☐ Not stated

◯ Conditional consent obtained but organ/tissue donation was not possible

- ◯ Consent for organ only but cardiac death
- ◯ Time constraint because of logistic
- ◯ Unacceptable; directed donation

◯ Not applicable

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SECTION 10 : CONSENT FOR ORGAN & TISSUE DONATION (Continue)

5. Organ / tissue * Consented & Procured:

Organ / tissue	Consent obtained?	Procured?	Reason for non-procurement
a. Heart:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Organ/tissue in poor condition ◯ No blood group match ◯ No size match ◯ Logistic difficulties/problems ◯ Recipient refused ◯ Became cardiac death ◯ Donor/organ not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____
b. Lungs:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Organ/tissue in poor condition ◯ No blood group match ◯ No size match ◯ Logistic difficulties/problems ◯ Recipient refused ◯ Became cardiac death ◯ Donor/organ not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____
c. Liver:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Organ/tissue in poor condition ◯ No blood group match ◯ No size match ◯ Logistic difficulties/problems ◯ Recipient refused ◯ Became cardiac death ◯ Donor/organ not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____
d. Kidneys:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Organ/tissue in poor condition ◯ No blood group match ◯ No size match ◯ Logistic difficulties/problems ◯ Recipient refused ◯ Became cardiac death ◯ Donor/organ not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____
e. Heart valves:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Logistic difficulties/problems ◯ Recipient refused ◯ Donor/tissue not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____
f. Eyes:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Logistic difficulties/problems ◯ Recipient refused ◯ Donor/tissue not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____
g. Bone:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Logistic difficulties/problems ◯ Recipient refused ◯ Donor/tissue not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____
h. Skin:	◯ Yes → ◯ No	◯ Yes ◯ No →	◯ Logistic difficulties/problems ◯ Recipient refused ◯ Donor/tissue not suitable → ☐ Unacceptable cancer ☐ Transmissible disease ☐ Overwhelming sepsis ☐ Presence of risk factors ☐ Unsuitable age group ☐ Others, specify: ____ ◯ Others, specify: ____

6. Organ/tissue procured but not transplanted:

a. Organ/tissue

☐ Heart →	Reason :	☐ Positive Serology	☐ Others, specify: ____
☐ Lungs →	Reason :	☐ Positive Serology	☐ Others, specify: ____
☐ Liver →	Reason :	☐ Positive Serology	☐ Others, specify: ____
☐ Kidneys →	Reason :	☐ Positive Serology	☐ Others, specify: ____
☐ Heart valves →	Reason :	☐ Positive Serology	☐ Others, specify: ____
☐ Eyes →	Reason :	☐ Positive Serology	☐ Others, specify: ____
☐ Bone →	Reason :	☐ Positive Serology	☐ Others, specify: ____
☐ Skin →	Reason :	☐ Positive Serology	☐ Others, specify: ____

7. If organ / tissue unable to be transplanted, family agreed for tissues to be:

☐ Used for research ☐ To be returned back to family ☐ Respectfully disposed as per deceased religion ☐ Others, specify: ____

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SECTION 11 : DONOR FAMILY INFORMATION

1. Name :

2. NRIC :

MyKad / MyKid: ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC: ☐☐☐☐☐☐☐☐

Other ID document No:

Specify document type (if others):
◯ Army ◯ Father's IC ◯ Birth Certificate ◯ Others: .....
◯ Police ◯ Work Permit ◯ Pension Card
◯ Mother's IC ◯ Passport

3. Address:

Postcode: ☐☐☐☐☐ Town / City:

State :
◯ Johor Darul Takzim ◯ Pahang Darul Makmur ◯ Sarawak ◯ Wilayah Persekutuan Labuan
◯ Kedah Darul Aman ◯ Perak Darul Ridzuan ◯ Selangor Darul Ehsan
◯ Kelantan Darul Naim ◯ Perlis Indera Kayangan ◯ Terengganu Darul Iman ◯ Wilayah Persekutuan Putrajaya
◯ Melaka ◯ Pulau Pinang ◯ Wilayah Persekutuan Kuala Lumpur
◯ Negeri Sembilan Darul Khusus ◯ Sabah ◯ Not applicable - Foreign

4. Contact number:

Home ☐☐☐ - ☐☐☐☐☐☐☐ Handphone: ☐☐☐ - ☐☐☐☐☐☐☐

5. Email:

6. Gender:

◯ Male ◯ Female

7. Relationship:

◯ Parents ◯ Spouse ◯ Children ◯ Siblings ◯ Others, specify: ..... Add

---

1. Name :

2. NRIC :

MyKad / MyKid: ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC: ☐☐☐☐☐☐☐☐

Other ID document No:

Specify document type (if others):
◯ Army ◯ Father's IC ◯ Birth Certificate ◯ Others: .....
◯ Police ◯ Work Permit ◯ Pension Card
◯ Mother's IC ◯ Passport

3. Address:

Postcode: ☐☐☐☐☐ Town / City:

State :
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4. Contact number:

Home ☐☐☐ - ☐☐☐☐☐☐☐ Handphone: ☐☐☐ - ☐☐☐☐☐☐☐

5. Email:

6. Gender:

◯ Male ◯ Female

7. Relationship:

◯ Parents ◯ Spouse ◯ Children ◯ Siblings ◯ Others, specify: ..... Add

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SECTION 12 - 23 DONOR MANAGEMENT

SECTION 12 : DONOR CHECKLIST - MEDICO-LEGAL CASE

1. Medico-legal * case? ◯ Yes → ◯ No

a) Type : *	☐ Homicide ☐ Accident ☐ Others, specify: ☐ Suicide ☐ Sudden death ----------
b) i. Magistrate consent * obtained?	◯ Yes → ◯ No
b) ii. Name of magistrate:	
b) iii. Office address:	
b) iv. Contact number:	☐☐☐ - ☐☐☐☐☐☐☐☐

2. Post mortem: ◯ Yes → ◯ No

a. Post mortem type:	◯ Mandatory ◯ Family requested
b. Date & time: (dd/mm/yyyy)	☐☐ / ☐☐ / ☐☐☐☐ **Time:** ☐☐☐☐ (24 hrs clock)

3. Forensic Pathologist

a. Name:

b. Contacted: ◯ Yes → ◯ No

i. Date & time: (dd/mm/yyyy)	☐☐ / ☐☐ / ☐☐☐☐ **Time:** ☐☐☐☐ (24 hrs clock)

c. Clearance obtained: ◯ Yes → ◯ No

i. Any restrictions:	

4. Police

a. Contacted: ◯ Yes → ◯ No

i. Date & time: (dd/mm/yyyy)	☐☐ / ☐☐ / ☐☐☐☐ **Time:** ☐☐☐☐ (24 hrs clock)
ii. Name:	
iii. Police ID #:	
iv. Contact number:	
v. Station:	

b. Clearance obtained: ◯ Yes ◯ No

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SECTION 13 : CONFIDENTIAL DONOR HISTORY

☐ None

	History	Specify
a. Medical history:	☐ Influenza-like illness (ILI)	
	☐ Heart disease (including family history)	
	☐ High blood pressure (hypertension) → i. Treated for how long? ____ years	
	☐ Diabetes → i. Treatment : ☐ Oral medication ☐ Insulin	
	☐ Asthma or any lung disease or has been treated for tuberculosis (TB) or atypical pneumonia	
	☐ Kidney disease	
	☐ Liver disease or jaundice	
	☐ Eye disease, infection, cataracts, corneal disease or operations or trauma involving the eyes	
	☐ Arthritis or joint disease? e.g. osteoporosis, osteoarthritis, paget's disease, rheumatoid arthritis, connective tissue disease such as systemic lupus erythematosus	
	☐ Been hospitalised in the past 2 years	
	☐ Ever received an organ or tissue transplant	
	☐ Ever had a cancer or received chemotherapy, radiotherapy or treatment for cancer	
	☐ Ever suffered any types of dementia or brain disease such as alzheimers, seizures, memory loss, history of brain tumour or meningitis	
	☐ History of long term fever, infection or unexplained weight loss	
	☐ History of blood transfusion	
	☐ History of skin disease	
	☐ Others	
b. Surgical history:	☐ Had any serious illness or operation performed in the past	
	☐ Others	
c. Social history:	☐ Exposure to toxic substancs e.g. lead, pesticides or others → i. Occupation at that time, specify:	
	☐ Ever drink alcohol → ◯ Occasional ◯ Frequent ◯ Heavy ◯ Unknown	
	☐ Ever smoked → ◯ Former (quit > 30 days) ◯ Current ◯ Unknown	
	☐ Intravenous drug user	
	☐ In the past 12 months, had a tattoo, body piercing, stud piercing, acupuncture or accidental needle stick injury	
	☐ Any sexual risk factors	
	☐ Others	
d. Medication:	☐ Taken any medication on a regular basis	
	☐ Taken any antimalarial drugs (history of Malaria or typhus)	
	☐ Been vaccinated or immunised in the past 12 months for any reason	
	☐ Ever been given pituitary growth or fertility hormone	
	☐ Ever used non-prescribed drugs IV steroids, heroin, other illegal drugs or inhalants or herbs or traditional medications or supplements	
	☐ Others	

SECTION 14 : ADVERSE EVENTS

1. Cardiac arrest: ◯ Yes → ◯ No

i. CPR?	◯ Yes → ◯ No
ii. Duration: *	____ minutes
iii. Remarks:	
iv. Type of arrest:	☐ Asystole ☐ VF ☐ VT ☐ PEA ☐ Others, specify: ____
v. Treatment	☐ Drugs, specify: ____ ☐ Others, specify: ____ ☐ Defibrillation, specify the frequency: ____

2. BP < 70 mmHg SYST: ◯ Yes → ◯ No ____ mmHg for ____ hours ____ minutes

3. Temperature <35 °C: ◯ Yes → ◯ No Remarks: ____

4. Temperature >39 °C: ◯ Yes → ◯ No Remarks: ____

5. Oliguria: ◯ Yes → ◯ No i) < 0.5 mls/kg/hr for ____ hours ii) Urine colour ◯ Clear ◯ Haematuria ◯ Concentrated ◯ Cloudy

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SECTION 15: HAEMODYNAMICS MEASUREMENTS

1. Date & time: / / (dd/mm/yyyy) **Time:** (24 hrs clock) ☐ Not Done

Haemodynamics	Results
1. BP: Systolic / Disatolic (mmHg)	/
2. MAP: (mmHg)	
3. HR: (beats/min)	
4. CVP:	◉ (+)ve ◉ (-)ve ◉ cmH2O ◉ mmHg
5. Temperature: ($_{o}$C)	
6. a) U/O: (mls/hr)	
6. b) U/O 24 hrs: (mls/24hrs)	

7. Supported by Ionotrope: ◉ Yes ◉ No

i. Type:

- ☐ Dopamine → Dose: mcg/kg/min
- ☐ Dobutamine → Dose: mcg/kg/min
- ☐ Noradrenaline → Dose: mcg/kg/min
- ☐ Adrenaline → Dose: mcg/kg/min
- ☐ Others, specify: → Dose: Unit:

ADD

SECTION 16: LABORATORY RESULTS

Section 16a: Biochemistry

1. Date & time: / / (dd/mm/yyyy) **Time:** (24 hrs clock) ☐ Not Done

Biochemistry	Results	Normal Range
1. Sodium (Na):	mmol/L ☐ ND	135 - 150
2. Potassium (K):	mmol/L ☐ ND	3.5 - 4.5
3. Urea:	g/L ☐ ND	3.0 - 8.0
4. Chloride:	g/L ☐ ND	96 - 108
5. Creatinine	mmol/L ☐ ND	0.05 - 0.12
6. Total Protein:	g/L ☐ ND	63 - 80
7. Albumin:	g/L ☐ ND	35 - 50
8. Globulin:	g/L ☐ ND	19 - 36
9. A/G ratio:	☐ ND	
10. Total bilirubin:	mmol/L ☐ ND	0 - 20
11. ALP:	U/L ☐ ND	35 - 116
12. AST:	U/L ☐ ND	0 - 40

Biochemistry	Results	Normal Range
13. ALT:	U/L ☐ ND	0 - 40
14. GGT:	U/L ☐ ND	0 - 60
15. Glucose:	mmol/L ☐ ND	3.2 - 7.5
16. Lipase:	mmol/L ☐ ND	7 - 60
17. Amylase:	U/L ☐ ND	20 - 100
18. CK:	U/L ☐ ND	< 160
19. Troponin	µg/L ☐ ND	< 0.7
20. Calcium:	mmol/L ☐ ND	2.25 - 2.60
21. Lactate:	mmol/L ☐ ND	4.5 - 14.5
22. Magnesium:	mmol/L ☐ ND	0.8 - 1
23. Phosphate:	mmol/L ☐ ND	0.84 - 1.45
24. Remarks:		

ADD

Section 16b: Haematology

1. Date & time: / / (dd/mm/yyyy) **Time:** (24 hrs clock) ☐ Not Done

Haematology	Results	Reference Range
1. Hb:	g/L ☐ ND	120 - 170
2. HCT:	% ☐ ND	0.37 - 0.49
3. WBC:	x 10^{9}/L ☐ ND	4 - 10.50
4. Platelet:	x 10^{9}/L ☐ ND	150 - 400
5. PT:	secs ☐ ND	11 - 15

Heamatology	Results	Reference Range
6. APPT:	g/L ☐ ND	25 - 38
7. Fibrin:	µmol/L ☐ ND	1.5 - 4.0
8. INR:	☐ ND	0.9 - 1.3
9. Remarks:		

ADD

SECTION 17: GAS EXCHANGE

1. Date & time: / / (dd/mm/yyyy) **Time:** (24 hrs clock) ☐ Not Done

Gas Exchange	Results	Reference Range
1. pH	☐ ND	7.35 - 7.45
2. PaO2	mmHg ☐ ND	75 - 100
3. PaCO2	mmHg ☐ ND	35 - 45
4. B.E:	◉ (+)ve ◉ (-)ve ☐ ND	-2.5 - +2.5
5. HCO_3	mmol/L ☐ ND	21 - 28

Gas Exchange	Results	Reference Range
6. FiO_2	% ☐ ND	
7. PEEP	☐ ND	
8. TV	ml ☐ ND	
9. PaO_2/FiO_2 (at 100%) for 5 min	mm mercury ☐ ND	
10. Remarks:		

ADD

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SECTION 18 : MICROBIOLOGY CULTURE

Mircobiology	Findings	Date and time
1. Blood	◯ Normal ◯ Abnormal → ◯ Not done	__/__/____ (dd/mm/yyyy) Time: ____ (24 hrs clock)
2. Urine	◯ Normal ◯ Abnormal → ◯ Not done	__/__/____ (dd/mm/yyyy) Time: ____ (24 hrs clock)
3. Sputum, Tracheal aspirate / BAL (Bronchoalveolar lavage)	◯ Normal ◯ Abnormal → ◯ Not done	__/__/____ (dd/mm/yyyy) Time: ____ (24 hrs clock)
4. Others, specify: ____	◯ Normal ◯ Abnormal → ◯ Not done	__/__/____ (dd/mm/yyyy) Time: ____ (24 hrs clock)

ADD

SECTION 19 : SEROLOGY

*1. Date & time: __/__/____ (dd/mm/yyyy) Time: ____ (24 hrs clock)

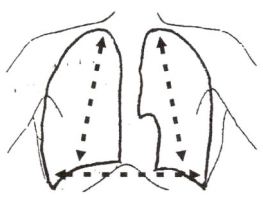
Serology	Results	Serology	Results
*1. HIV:	◯ Negative ◯ Positive ◯ Not done	*7a. CMV IgG:	◯ Negative ◯ Positive ◯ Not done
*2. HBs Antigen:	◯ Negative ◯ Positive ◯ Not done	*7b. CMV IgM:	◯ Negative ◯ Positive ◯ Not done
*3. Anti HBsAb:	◯ Negative ◯ Positive ◯ Not done	*8a. Toxoplasmosis IgG:	◯ Negative ◯ Positive ◯ Not done
*4. Anti Hep B Core Ab TOTAL:	◯ Negative ◯ Positive ◯ Not done	*8b. Toxoplasmosis IgM:	◯ Negative ◯ Positive ◯ Not done
		*9. EBV:	◯ Negative ◯ Positive ◯ Not done
*5. Anti HCV:	◯ Negative ◯ Positive ◯ Not done	10. Others, specify	◯ Negative ◯ Positive ◯ Not done
*6. VDRL:	◯ Negative ◯ Positive ◯ Not done	11. Remarks:	ADD

SECTION 20 : OTHER INVESTIGATIONS & RELEVANT INFORMATION

☐ None

Investigations	Check if performed	Date & Time (dd/mm/yyyy)	Results	Reported by: Name
1. ECG	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	
2. ECHO	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	
3. CXR	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	
4. Bronchoscopy	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	
5. CT Brain	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	
6. Ultrasound- Liver	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	
7. Ultrasound- Kidney	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	
8. Others, specify: ____	☐	__/__/____ Time: ____ (24 hrs clock)	◯ Normal ◯ Abnormal →	

9. Aspiration:	◯ Yes	◯ No	
10. Tracheostomy:	◯ Yes	◯ No	
11. Chest Drain	◯ Yes → ☐ Right ☐ Left	◯ No	
12. Sputum (colour / quantity /			
13. Lung measurements:	a. Left lung: (Apex to Base)	__.__ cm	
	b. Right lung: (Apex to Base)	__.__ cm	
	c. Transthoracic: (Widest points)	__.__ cm	



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SECTION 21 : CARDIAC STATUS

1. Date & time: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy) **Time:** __ __ __ __ (24 hrs clock) ☐ Not Done

Cardiac Status	Results	Cardiac Status	Results
1. Cardiac Index: (L/min/m^2)	______ ☐ ND	**3. Cardiac output:** (L / min)	______ ☐ ND
2. SVR: (dyne s /cm^5)	______ ☐ ND		ADD

SECTION 22 : TERMINAL TREATMENT IN ICU

1a. Inotropes/ Vasopressor ◯ Yes → ◯ No

Medication	Date Start & Time Start (dd/mm/yyyy)	Date Stop & Time End (dd/mm/yyyy)	Concentration (mg/ml)	Max Dose	mls/ hr	Mcg/Kg/min (Auto calc)
◯ Dopamine ◯ Adrenaline ◯ Noradrenaline ◯ Others,specify: ______ ◯ Dobutamine	__ / __ / ____ Time start: __ : __	__ / __ / ____ Time end: __ : __				ADD
◯ Dopamine ◯ Adrenaline ◯ Noradrenaline ◯ Others,specify: ______ ◯ Dobutamine	__ / __ / ____ Time start: __ : __	__ / __ / ____ Time end: __ : __				ADD
◯ Dopamine ◯ Adrenaline ◯ Noradrenaline ◯ Others,specify: ______ ◯ Dobutamine	__ / __ / ____ Time start: __ : __	__ / __ / ____ Time end: __ : __				ADD

2. IV Fluids

Type of fluids	Date Start & Time Start (dd/mm/yyyy)	Date Stop & Time End (dd/mm/yyyy)	Volume	Unit	Route
◯ Crystalloid → **◯ Dextrose 5% ◯ Hartmann** **◯ Dextrose Salin** **◯ 1/5 Dextrose Salin** **◯ Normal Saline** **◯ Half Saline** **◯ Others, specify:** ______ **◯ Colloid** → **◯ Gelafundin ◯ Hetastarch** **◯ Hemaccel ◯ Voluven** **◯ Others, specify:** ______ **◯ Blood** → **◯ Whole Blood ◯ Packed cell** **◯ Others, specify:** ______ **◯ Blood produ** → **◯ Platelet ◯ FFP ◯ Cyro** **◯ Others, specify:** ______ **◯ Water** **◯ Others, specify:** ______	__ / __ / ____ **Time start:** __ : __	__ / __ / ____ **Time end:** __ : __			**◯ IV** **◯ Nasogastric tube** **◯ Others, specify:** ______ **ADD**
◯ Crystalloid → ◯ Dextrose 5% ◯ Hartmann ◯ Dextrose Saline ◯ 1/5 Dextrose Saline ◯ Normal Saline ◯ Half Saline ◯ Others, specify: ______ ◯ Colloid → ◯ Gelafundin ◯ Hetastarch ◯ Hemaccel ◯ Voluven ◯ Others, specify: ______ ◯ Blood → ◯ Whole Blood ◯ Packed cell ◯ Others, specify: ______ ◯ Blood product → ◯ Platelet ◯ FFP ◯ Cyro ◯ Others, specify: ______ ◯ Water ◯ Others, specify: ______	__ / __ / ____ Time start: __ : __	__ / __ / ____ Time end: __ : __			◯ IV ◯ Nasogastric tube ◯ Others, specify: ______ ADD

Instruction: Where check boxes are provided, check (√) one or more boxes. Where radio buttons are provided, check (√) one box only.

SECTION 22 : TERMINAL TREATMENT IN ICU (Continue)

3a.Hormonal replacement:

Medication	Date Start & Time Start (dd/mm/yyyy)	Date Stop & Time End (dd/mm/yyyy)	Dose	Units	Freq
Methylprednisolone Insulin / Vasopressin T3 / DDAVP Others, specify:	/ / Time start: :	/ / Time end: :		mg unit µg (microgram) Others,specify:	ADD
Methylprednisolone Insulin / Vasopressin T3 / DDAVP Others, specify:	/ / Time start: :	/ / Time end: :		mg unit µg (microgram) Others,specify:	ADD
Methylprednisolone Insulin / Vasopressin T3 / DDAVP Others, specify:	/ / Time start: :	/ / Time end: :		mg unit µg (microgram) Others,specify:	ADD
Methylprednisolone Insulin / Vasopressin T3 / DDAVP Others, specify:	/ / Time start: :	/ / Time end: :		mg unit µg (microgram) Others,specify:	ADD

4. Antibiotics: Yes → No

Medication	Date Start & Time Start (dd/mm/yyyy)	Date Stop & Time End (dd/mm/yyyy)	Dose	Units	Freq
	/ / Time start: :	/ / Time end: :			ADD
	/ / Time start: :	/ / Time end: :			ADD
	/ / Time start: :	/ / Time end: :			ADD
	/ / Time start: :	/ / Time end: :			ADD

5. Other medications: Yes → No

Medication	Date Start & Time Start (dd/mm/yyyy)	Date Stop & Time End (dd/mm/yyyy)	Dose	Units	Freq
	/ / Time start: :	/ / Time end: :			ADD
	/ / Time start: :	/ / Time end: :			ADD
	/ / Time start: :	/ / Time end: :			ADD
	/ / Time start: :	/ / Time end: :			ADD

6. Enteral feeding including water: Yes → No

Types of enteral feeds	Date Start & Time Start (dd/mm/yyyy)	Date Stop & Time End (dd/mm/yyyy)	Max Volume per day (mls/hr)	Freq
	/ / Time start: :	/ / Time end: :		ADD
	/ / Time start: :	/ / Time end: :		ADD
	/ / Time start: :	/ / Time end: :		ADD
	/ / Time start: :	/ / Time end: :		ADD

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SECTION 23 : REFERRAL TO RECIPIENT'S COORDINATOR

1. Organ / tissue:	☐ Heart ☐ Liver ☐ Heart valve ☐ Cornea ☐ Lung ☐ Kidney ☐ Skin ☐ Bone
2. Hospital name:	
3. Coordinator name:	
4. Contact number:	
5. Date & time offered:	/ / Time: (24hrs clock)
6. Date & time accepted:	/ / Time: (24hrs clock)
7. Date & time rejected:	/ / Time: (24hrs clock) ADD

1. Organ / tissue:	☐ Heart ☐ Liver ☐ Heart valve ☐ Cornea ☐ Lung ☐ Kidney ☐ Skin ☐ Bone
2. Hospital name:	
3. Coordinator name:	
4. Contact number:	
5. Date & time offered:	/ / Time: (24hrs clock)
6. Date & time accepted:	/ / Time: (24hrs clock)
7. Date & time rejected:	/ / Time: (24hrs clock) ADD

1. Organ / tissue:	☐ Heart ☐ Liver ☐ Heart valve ☐ Cornea ☐ Lung ☐ Kidney ☐ Skin ☐ Bone
2. Hospital name:	
3. Coordinator name:	
4. Contact number:	
5. Date & time offered:	/ / Time: (24hrs clock)
6. Date & time accepted:	/ / Time: (24hrs clock)
7. Date & time rejected:	/ / Time: (24hrs clock) ADD

1. Organ / tissue:	☐ Heart ☐ Liver ☐ Heart valve ☐ Cornea ☐ Lung ☐ Kidney ☐ Skin ☐ Bone
2. Hospital name:	
3. Coordinator name:	
4. Contact number:	
5. Date & time offered:	/ / Time: (24hrs clock)
6. Date & time accepted:	/ / Time: (24hrs clock)
7. Date & time rejected:	/ / Time: (24hrs clock) ADD

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SECTION 24 - 29 PROCUREMENT

SECTION 24 : PERI-OPERATIVE INFORMATION

1. OT Phone number:		**2. Contact person in OT:**	
3. Date and Time donor arrive to OT:	/ / (dd/mm/yyyy)		(24hrs clock)
4. Date and Time surgery start:	/ / (dd/mm/yyyy)		(24hrs clock)
5. Date and Time surgery end:	/ / (dd/mm/yyyy)		(24hrs clock)
6. Viewing:	◉ Yes ◉ No		
7. Facilitated by:			
8. Place of viewing:			
9. Date & time of morgue:	/ / (dd/mm/yyyy)		(24hrs clock)
10. Date & time of body release:	/ / (dd/mm/yyyy)		(24hrs clock)

SECTION 25 : ORGAN PROCUREMENT SURGERY

Section 25a : CARDIOTHORACIC ORGAN

1. Thoracic retrieval surgeon's Name:		ADD	
1. Heart		**2. Lung**	
2. Heart procured	◉ Yes → ◉ No	**3. Lung procured**	◉ Yes → ◉ No
2a. Perfusion pneumoplegia: (mls)		**3a. Perfusion pneumoplegia:** (mls)	
2b. Technical problem, specify:		**3b. Technical problem, specify:**	
2c. Problem with cardioplegia:		**3c. Collapse**	◉ Yes ◉ No
2d. Myocardial contusion:		**3d. Contusion:**	◉ Yes ◉ No
		3e. Sputum / secretions:	◉ Yes ◉ No
2e. Coronary artery disease:2		**3f. Consolidation:**	◉ Yes ◉ No
		3g. Cysts:	◉ Yes ◉ No
2f. Location:		**3h. Easily deflated:**	◉ Yes ◉ No
		3i. Damage to left bronchi:	◉ Yes ◉ No
2g. Ventricular contraction function:		**3j. Damage to right bronchi:**	◉ Yes ◉ No
		3k. Chest drains:	◉ Yes ◉ No
2h. Any anatomical abnormality or damage:	◉ Yes → ◉ No	**3l. Any anatomical abnormality or damage:**	◉ Yes → ◉ No
4. Comments:			

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SECTION 25 : ORGAN PROCUREMENT SURGERY (continue)

Section 25b : ABDOMINAL ORGANS

1. Abdominal retrieval surgeon's Name:	
A. Cross - clamp date & time:	/ / (dd/mm/yyyy) (24hrs clock)

B. Fluid for Flushing

I. First Flush	Volume (mls)	II. Second Flush	Volume (mls)
1. 0.9% NaCl:		1. 0.9% NaCl:	
2. HARTMANS:		2. HARTMANS:	
3. Uero Collin:		3. Uero Collin:	
4. U.W:		4. U.W:	
5. Other:		5. Other:	

C. Kidney Procurement

		i. Right	ii. Left
1. Side:		☐ Right →	☐ Left →
2. Quality of perfusion:			
3. Appearance after perfusion:			
4. Artheroma:			
5. Number of vessels	i. Artery:		
	ii. Vein:		
	iii. Ureter:		
6. Biopsy:		◯ Yes ◯ No	◯ Yes ◯ No
7. Recipient Hospital:			
8. Any anatomical abnormality or damage:		◯ Yes → ◯ No	◯ Yes → ◯ No
9. Spleen taken:		◯ Yes ◯ No	

D. Liver Procurement

1. Pancreas separated from liver:	(24 hrs clock)		
2. Time into transport container:	(24 hrs clock)		
3. a) Warm ischaemic time: (if any)	(24 hrs clock)	3. b) Duration from cross-clamp to warm ischaemic time: (Autocalculate)	(Hrs)
4. Insitu liver split:	(24 hrs clock)		
5. Fatty liver:	◯ Yes ◯ No		
6. Aortic arterial disease:	◯ Yes ◯ No		
7. Biopsy:	◯ Yes → ◯ No a. Findings:		
8. Surgeon's assessment of perfusion:	◯ Rapid ◯ Patchy ◯ Others, specify		
9. Comments:			

SECTION 26 : FAMILY SATISFACTION

1. Family satisfaction with the process & state of the body:	◯ 1 (Not satisfied at all) ◯ 2 (Not satisfied) ◯ 3 (Partially satisfied) ◯ 4 (Satisfied) ◯ 5 (Highly satisfied)
i. Reason not satisfied:	☐ Delay, cause : _____ ☐ Communication skill ☐ State of the body ☐ Others, specify

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SECTION 27 : PROBLEMS

1. Problems faced:

- ☐ None
- ☐ Donor maintenance
- ☐ Family related issues
- ☐ Medical legal issues
- ☐ Communication & interpersonal interaction
- ☐ Media related issues
- ☐ Others, specify : _____
- ☐ Logistic →
  - ☐ Transportation
  - ☐ Recipient refused
  - ☐ Others, specify _____
  - ☐ Operating Theater (OT) or the facility or equipment not available
  - ☐ Staff are not available , no cooperation

2. Details (if any):

SECTION 28 : RETRIEVAL TEAM / HOSPITAL STAFF DETAILS

#	Name	Designation	Donor Hospital Staff/ Retrieval teams	Comments
		◯ Surgeon ◯ Matron ◯ Sister ◯ Nurse ◯ Anaesthesia ◯ Paramedic ◯ Others, specify _____	◯ Donor Hospital Staff → ◯ ICU ◯ Operating room ◯ Anaesthesia ◯ Others, specify _____ ◯ Retrieval teams → ☐ Abdominal ☐ Thoracic ☐ Tissue → ☐ Eye ☐ Skin ☐ Bone ☐ Heart Valve ☐ Others, specify _____ ◯ Others, specify: _____	ADD
		◯ Surgeon ◯ Matron ◯ Sister ◯ Nurse ◯ Anaesthesia ◯ Paramedic ◯ Others, specify _____	◯ Donor Hospital Staff → ◯ ICU ◯ Operating room ◯ Anaesthesia ◯ Others, specify _____ ◯ Retrieval teams → ☐ Abdominal ☐ Thoracic ☐ Tissue → ☐ Eye ☐ Skin ☐ Bone ☐ Heart Valve ☐ Others, specify _____ ◯ Others, specify: _____	ADD

SECTION 29 : TRANSPORT DETAILS

#	Organ / Tissue	Transport	Comments
	☐ Heart ☐ Lung ☐ Liver ☐ Kidney ☐ Heart valve ☐ Skin ☐ Cornea ☐ Bone	☐ Ambulance → ☐ Police outrider ☐ TUDM ☐ TLDM ☐ ATM ☐ Car ☐ Others, specify **i. Hospital Name:**	ADD
	☐ Heart ☐ Lung ☐ Liver ☐ Kidney ☐ Heart valve ☐ Skin ☐ Cornea ☐ Bone	☐ Ambulance → ☐ Police outrider ☐ TUDM ☐ TLDM ☐ ATM ☐ Car ☐ Others, specify **i. Hospital Name:**	ADD

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SECTION 30 : RECIPIENT PARTICULAR (CONFIDENTIAL)

1. Organ / tissue: *

- ◯ Heart
- ◯ Lung → ◯ Single ◯ Double
- ◯ Heart & Lung
- ◯ Liver → ◯ Whole ◯ Split
- ◯ Kidney → ◯ Right ◯ Left ◯ Both
- ◯ Heart valve
- ◯ Bone
- ◯ Cornea → ◯ Right ◯ Left ◯ Both
- ◯ Skin

2. Transplant Hospital:

3. Name : *
(Please print in capital letters)

4. NRIC : *

MyKad / MyKid: ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC: ☐☐☐☐☐☐☐☐

Other ID document No:

Specify document type (if others):

- ◯ Army
- ◯ Police
- ◯ Mother's IC
- ◯ Father's IC
- ◯ Work Permit
- ◯ Passport
- ◯ Birth Certificate
- ◯ Pension Card
- ◯ Others: .....

5. Address:

Postcode: ☐☐☐☐☐ Town / City:

State :
- ◯ Johor Darul Takzim
- ◯ Kedah Darul Aman
- ◯ Kelantan Darul Naim
- ◯ Melaka
- ◯ Negeri Sembilan Darul Khusus
- ◯ Pahang Darul Makmur
- ◯ Perak Darul Ridzuan
- ◯ Perlis Indera Kayangan
- ◯ Pulau Pinang
- ◯ Sabah
- ◯ Sarawak
- ◯ Selangor Darul Ehsan
- ◯ Terengganu Darul Iman
- ◯ Wilayah Persekutuan Kuala Lumpur
- ◯ Wilayah Persekutuan Labuan
- ◯ Wilayah Persekutuan Putrajaya
- ◯ Not applicable - Foreign

6. Date of Birth: (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ ☐ Estimated / presumed year (autofill if MyKad is available)
If the exact date is not known, please enter 01/07/yyyy & check the estimated/presumed year box

7. Age at transplant: (autocalculate) ☐☐.☐☐ (years)

8. Gender: *
- ◯ Male
- ◯ Female

9. Ethnic group: *
- ◯ Malay
- ◯ Chinese
- ◯ Indian
- ◯ Bumiputera Sabah, specify _____
- ◯ Bumiputera Sarawak, specify _____
- ◯ Orang Asli
- ◯ Others: .....

10. Diagnosis:

11. Transplant * start date & time: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) **Time:** ☐☐☐☐ (24 hrs clock)

12. Transplant * end date & time: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) **Time:** ☐☐☐☐ (24 hrs clock)

13. Cold-ischemic * duration: ☐☐☐ (hours) ☐☐ (mins)

14. Outcome: *
- ◯ Successful
- ◯ Not successful
- ◯ Others, specify .....

15. Comments:

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SECTION 31 : SUMMARY OF ORGAN/TISSUE PROCURED

Organ / Tissue	Consent obtained (Autofill)	Procured (Autofill)	No. procured	No. transplanted	No. of recipient(s)
1. Heart	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1	◯ 1 ◯ Not Done	◯ 1 ◯ Not Done
2. Lungs	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1 ◯ 2	◯ 1 ◯ 2 ◯ Not Done	◯ 1 ◯ 2 ◯ Not Done
3. Heart & Lung			◯ 1	◯ 1 ◯ Not Done	◯ 1 ◯ Not Done
4. Liver	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1	◯ 1 ◯ 2 ◯ Not Done	◯ 1 ◯ 2 ◯ Not Done
5. Kidneys	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1 ◯ 2	◯ 1 ◯ 2 ◯ Not Done	◯ 1 ◯ 2 ◯ Not Done
6. Heart valve	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1	◯ 1 ◯ Not Done	◯ 1 ◯ Not Done
7. Eyes	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1 ◯ 2	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Not Done	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Not Done
8. Bone	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1	◯ 1 ◯ Not Done	◯ 1 ◯ Not Done
9. Skin	◯ Yes ◯ No	◯ Yes ◯ No	◯ 1	◯ 1 ◯ Not Done	◯ 1 ◯ Not Done

(Note : If Procured for Heart = "Yes" and Lungs = "Yes", please complete No. procured, No. transplanted & No. of recipient(s) for "Heart" and "Lungs" or "Heart & Lung")

NATIONAL TRANSPLANT PROCUREMENT MANAGEMENT UNIT
Centre & Procurement Team Details Form

For Office Use only:
ID: /
Centre:

Instruction: Where check boxes ☐ are provided, check (√) one or more boxes. Where radio buttons ◯ are provided, check (√) one box only.

SECTION 1: CENTRE DETAILS

1. Centre / Hospital name: Code:

2. Type of establishment:
- ◯ Government Hospital (State hospital)
- ◯ Government Hospital (District hospital)
- ◯ Others, specify _____
- ◯ Government Institution
- ◯ University Hospital
- ◯ Private Hospital
- ◯ Medical organization
- ◯ Clinic
- ◯ Medical Lab

3. Address:

Postcode: Town / City:

State :
- ◯ Johor Darul Takzim
- ◯ Kedah Darul Aman
- ◯ Kelantan Darul Naim
- ◯ Melaka
- ◯ Negeri Sembilan Darul Khusus
- ◯ Pahang Darul Makmur
- ◯ Perak Darul Ridzuan
- ◯ Perlis Indera Kayangan
- ◯ Pulau Pinang
- ◯ Sabah
- ◯ Sarawak
- ◯ Selangor Darul Ehsan
- ◯ Terengganu Darul Iman
- ◯ Wilayah Persekutuan Kuala Lumpur
- ◯ Wilayah Persekutuan Labuan
- ◯ Wilayah Persekutuan Putrajaya
- ◯ Not applicable - Foreign

4. Contact number (1): -

5. Contact number (2): -

6. Fax number: -

7. Comments:

ADD

SECTION 2: STAFF DETAILS

1. Name : * *(Please print in capital letters)*

Title: Name:

2. NRIC :

MyKad : - - Other ID document No:

Specify document type (if others):
- ◯ Army
- ◯ Police
- ◯ Work Permit
- ◯ Passport
- ◯ Pension Card
- ◯ Others: _____

3. Designation:
- ◯ Transplant coordinator
- ◯ TOP team
- ◯ Surgeon
- ◯ Matron
- ◯ Sister
- ◯ Nurse
- ◯ Anaesthetic
- ◯ Paramedic
- ◯ Pathologist
- ◯ Forensic Pathologist
- ◯ Magistrate
- ◯ Medical Lab Technician
- ◯ Army
- ◯ Police
- ◯ NTR Data Coordinator
- ◯ Transplant Procurement Manager
- ◯ Others, specify: _____

4. Gender:
- ◯ Male
- ◯ Female

5. Contact address:

Postcode: Town / City:

State :
- ◯ Johor Darul Takzim
- ◯ Kedah Darul Aman
- ◯ Kelantan Darul Naim
- ◯ Melaka
- ◯ Negeri Sembilan Darul Khusus
- ◯ Pahang Darul Makmur
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- ◯ Sabah
- ◯ Sarawak
- ◯ Selangor Darul Ehsan
- ◯ Terengganu Darul Iman
- ◯ Wilayah Persekutuan Kuala Lumpur
- ◯ Wilayah Persekutuan Labuan
- ◯ Wilayah Persekutuan Putrajaya
- ◯ Not applicable - Foreign

6. Contact number: (Office) - Ext:

7. Handphone no. -

8. Fax number: -

9. Email address (1):

10. Email address (2):

For Web Application Use

11. Date start: / / (dd/mm/yyyy)

12. Date left: / / (dd/mm/yyyy)

13. Allow Access to Web Application: ☐

14. Comments:

15. User Group:

16. User Name:

17. Password:

ADD