

PROFORMA FOR MONTHLY REPORTING OF TRANSPLANT OF ORGAN

Appropriate Authority Reg. ▼30/ 03/2028

Name of Or KIDNEY

Month: Mar-25

Name of the Hospital: Max Super Speciality Hospital Dehradun (U.K)

State: Uttarakhand

S. No	Type	Date of Retrieval/Transplant	Name	Address	Nationality	Age & Sex	NOTTO ID (Demographic ID)	CR No	Basic Diagnosis of Recipient	Donor relation with recipient a) Near Related* b) Other than near related** c) Cadaver# (BD/CD)	Competent / Authorization Authority Approval Date & No.(Which ever is applicable please indicate)	Source (In House/ Received from which Hospital) (please provide the details of cadaver)
1	Recipient	02/03/2025	Raksha Sharma Malkoti	II.No. 6 Friends enclave defence colony dehradun	Indian	31/ M	R250093163	MDDN 405735	Not Known	Near Related	21/01/2025	N/A
	Donor	02/03/2025	Magni Devi	229- Mothrowala Nokka Dehradun	Indian	66/ F	L250037910	MDDN 423092		Near Related		
2	Recipient											
	Donor											
3	Recipient											
	Donor											

Additional Information: Total No. of deceased persons who donated organs in the month of March 2025

i) after Brain Stem death.....NIL

ii. after cardiac death NIL

Signature of In-charge with Name & Designation

Email ID : Dr.atulkumar@maxhealthcare.com

Contact No. 9557404655

Dr. Sandeep Singh Tanwar
Vice President
Hospital Operations
Max Super Speciality Hospital
Malsi, Mussoorie
Dehradun - 248001

*In case of near related please specify whether the donor is mother, father, daughter, son etc of the recipient

**In case of Other than near related please specify whether the donor is Niece, aunt, uncle, nephew etc of the recipient

#If Cadaver death please specify Brain Death or Cardiac Death N/A

