

PROFORMA FOR MONTHLY REPORTING OF TRANSPLANT OF ORGAN

Appropriate Authority Reg. Valid Up 30/03/2028

Name of Or KIDNEY

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

Month: ^{Jan} JAN 2025

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											
	Donor											
2	Recipient		No Case Recorded in JAN 2025									
	Donor											
3	Recipient											
	Donor											

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

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

ii. after cardiac death NIL

Signature of In-charge with Name & Designation
 Email ID : Dr.atulkumar@maxhealthcare.
 Contact No. 9557404655
 Dr. Sandeep Singh Tanwar
 Senior Vice President
 Hospital Operations
 Max Super Speciality Hospital
 Malsi, Mussoorie Diversion Road
 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

