

PROFORMA FOR MONTHLY REPORTING OF TRANSPLANT OF ORGAN

Appropriate Authority Reg. Valid Upto.: 30/3/2028

Name of Organ: KIDNEY

Month: SEPT 2025

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/ Receiver from which Hospital) (please provide the details of cadaver)
1	Recipient											
	Donor											
2	Recipient		"No case Reported in SEPT 2025"									
	Donor											
3	Recipient											
	Donor											

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

i) after Brain Stem death..... Nil

ii. after cardiac death Nil

Signature of In-charge with Name & Designation
 Dr. Atul Kumar Singh Tanwar
 Senior Vice President
 Hospital Operations
 Max Super Speciality Hospital
 Malsi, Mussorie Division, Road
 Dehradun- 248001
 Email ID: Dr. atulkumar@maxhealthcare.com

*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