



**JEEVANDAN**

**(CADAVER TRANSPLANTATION PROGRAMME Govt.of Telangana)**

Andhra Pradesh Transplantation of Human Organs act 1995

**APPROPRIATE AUTHORITY FOR CADAVER TRANSPLANTATION (AACT)**

**BRAIN-STEM DEATH CERTIFICATE**

**(A) Patient Details:**

1. Name of the patient Shri/Smt./Km. ....

S.O./D.O/W.O. Shri. ....

Sex ..... Age .....

2. Home address .....

.....

3. Hospital Number .....

4. Name and Address .....

of next ofkin or person

Responsible forthe .....

Patient (if none exists, this

Must be specified) .....

5. has the patient or next of kin

Agreed to any transplant?.....

6. Is this a Police Case? Yes ..... No .....

**(B) Pre-conditions**

1. Diagnosis: Did the patient suffer from any illness or accident that led to irreversible brain damage? Specify details .....

.....

Date and time of accident/onset of illness.....

Date and onset of non-responsible coma.....

**Pre – Conditions**

**1. Diagnosis:** did the patient suffer from any illness or accident that led to irreversible brain damage? Specify

details.....  
.....

Date and time of accident of illness .....

Date and onset of non-responsible coma .....

**2. Findings of board of Medical Experts:**

(i) The following reversible causes of coma have been excluded: -

- Intoxication (Alcohol)
- Depressant Drugs
- Relaxants (Neuromuscular blocking agents)

First Medical Examination    Second Medical Examination

1<sup>st</sup> 2<sup>nd</sup>    1<sup>st</sup> 2<sup>nd</sup>

- Primary hypothermia
- Hypovolemic shock
- Metabolic or endocrine disorders
- Tests for absence or brain-stem functions

(ii) Coma

(iii) Cessation of spontaneous breathing

(iv) Pupillary size

(v) Pupillary light reflexes

(vi) Doll’s head eye movements

(vii) Corneal reflexes (Both sizes)

(viii) Motor response in any cranial nerve distribution, any responses to stimulation of face, limb or trunk

(ix) Gag reflex

(x) Cough (Tracheal)

(xi) Eye movements on coloric testing bilaterally



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**(2. Procedure for Apnea test)**

(xii) Apnoea tests as specified

(xiii) Were any respiratory movements seen?

.....

Date and time of first testing.....

Date and time of second testing.....

This is to certify that the patient has been carefully examined twice after an interval of about six hours and on the basis of findings recorded above.

Shri./Smt./Km. ....is declared brain-stem dead.

1. Medical Administrator Incharge

2. Authorized Specialist of the hospital

3. Neurologist/Neuro-Surgeon

4. Medical Officer Treating the patient.

NB. I. The minimum time interval between the first testing and second testing will be six hours.

II. No. 2 and No. 3 will be co-opted by the Administrator In charge of the hospital from the Panel of experts approved by the appropriate authority.