F O R M - 8

We, the following members of the Board of medical experts after careful personal examination hereby certify that Shri/Smt./Km _____ aged about _____ s/o, d/o, w/o, Shri _____ resident of _____

_____

is dead on account of permanent and irreversible cessation of all functions of the brain-stem. The tests carried out by us and the findings therein are recorded in the brain-stem death certificate annexed hereto.

Dated : _____ Signature _____

Place : _____

1. R.M.P. Incharge of the Hospital in which brain-Stem death has occurred
2. R.M.P., Nominated from the Panel of Names approved by the Appropriate Authority
3. Neurologist/Neuro-Surgeon Nominated from the panel of Names approved by the Appropriate Authority
4. R.M.P. treating the aforesaid deceased person.

BRAIN STEM DEATH CERTIFICATE

(A) PATIENT DETAILS:

1. NAME OF THE PATIENT — MR. /MS……
   S/O.D/O/W.O. — Mr ……..……..
   Sex…….Age……..
2. Home Address — ……..
3. Hospital Number — ……..
4. Name and Address of next of Kin or person responsible for the 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? ……

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……...

2. Findings of Board Medical Experts:

1. The following reversible causes of coma have excluded:-
   Intoxication (Alcohol)

   Depressant Drugs:

   Relaxants (Neuromuscular blocking agents)

	First Medical Examination		Second Medical Examination	
	1st	2nd	1st	2nd
Primary hypothermia				
Hypovolaemic shock				
Metabolic or Endo crine disorders				
Tests for absence of Brain stem functions.				
2. COMA				
3. Cessation for Spontaneous Breathing				

4. Pupillary size

5. Pupillary light Reflexes

6. Doll's head eye Movements.

7. corneal reflexes (Both sizes)

8. Motor response in any cranial nerve Distribution, any responses to stimulation Of face, limb of trunk.

9. Gag reflex.

10. Cough (Tracheal)

11. Eye movements on caloric testing Bilaterally.

12. Apnoea tests as specified

13. 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 finding recorded above.

Mr./Ms…….. is declared brain stem dead.

1. Medical Administrator Incharge of the hospital

2. Authorized Specialist

3. Neurologist/Neuro-Surgeon

4. Medical officer treating the patient

NB I. The Minimum time interval between the first testing and testing will be six Hours.

II No.2 and No.3 will be coopted by the Administrator Incharge of he hospital f From the panel of experts approved by appropriate authority.