HOSPITAL EMPANELMENT CHECKLIST
CHIEF MINISTER'S CARDIAC SURGERY PROGRAM

(More sheets can be added if required)

SECTION 1: Hospital Profile

Hospital Name: _____

District: _____

Address: _____

PHC Registration Number: _____ Issue Date: _____

PHC Regular License Number:_____ Expiry Date: _____

Name & Contact of Medical Superintendent/In-charge/CEO/COO: _____

Name & Contact of Focal Person from Program _____

Remarks: _____

SECTION 2: LEGAL & REGULATORY COMPLIANCE

☐ Valid PHC Regular License (private hospital)

☐ Valid PHC Registration (public hospital)

☐ Valid PBTA License

☐ Valid PNRA License

☐ Valid PRA / FBR registration

☐ No outstanding regulatory non-compliance notices

Status: ☐ Compliant ☐ Non-Compliant

Remarks: _____

SECTION 3: INFRASTRUCTURE & BED CAPACITY

☐ Total hospital beds ≥ 50 Available: _____

☐ ICU beds ≥ 6 Available: _____

☐ Dedicated CCU/ICU beds ≥ 5 Available: _____

☐ Minimum 2 operation theatres available Available: _____

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☐ At least 1 dedicated cardiac OT with laminar flow Available: _____

☐ Emergency services functional 24/7 No. of beds:_____

☐ In-house PBTA licensed blood bank available License Expiry Date : _____

☐ Central oxygen supply with backup available

☐ Power Backup – Generator / Hybrid Solar / UPS Capacity: _____

Remarks: _____

SECTION 4: HUMAN RESOURCES – CARDIAC SURGERY TEAM (MANDATORY)

☐ **Cardiac surgeon (FCPS/FRCS + ≥5 years consultant experience)**

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

☐ **Cardiac anesthesiologist (FCPS + ≥2 years cardiac experience)**

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Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

☐ **Full-time certified perfusionist available**

Name: _____ Experience: _____

Name: _____ Experience: _____

Name: _____ Experience: _____

☐ **Minimum 2 trained cardiac OT nurses available**

Name: _____ Experience: _____

Name: _____ Experience: _____

☐ **CCU/ICU nurses available (minimum 2 per shift)**

Morning

Name: _____ Experience: _____

Name: _____ Experience: _____

Evening

Name: _____ Experience: _____

Name: _____ Experience: _____

Night

Name: _____ Experience: _____

Name: _____ Experience: _____

(Duty Roaster Copy to be attached by the Hospital)

Remarks: _____

SECTION 5: SUPPORT SPECIALISTS AVAILABILITY

☐ **Cardiologist (full-time)**

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

☐ **Intensivist available (full-time / on-call)**

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

☐ **Nephrologist available (full-time / on-call)**

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

☐ **Pulmonologist available (full-time / on-call)**

Name: _____ Experience: _____

PMDC Number: _____ PMDC Expiry Date: _____

☐ **Biomedical engineer available (full-time / on-call)**

Name: _____ Experience: _____

Remarks: _____

SECTION 6: CLINICAL SCOPE

☐ Adult cardiac surgery services available

☐ Capability to perform all routine cardiac procedures (Fill Section -11 List of Procedures)

Remarks: _____

SECTION 7: QUALITY, SAFETY & GOVERNANCE

☐ Infection control SOPs available and implemented

☐ Blood transfusion SOPs available

☐ ICU SOPs available

☐ CCU SOPs available

☐ Infection Control Committee notified

☐ Morbidity & Mortality Committee Notified ☐ Functional ☐

(Attach Minutes of the meeting)

☐ Adverse event reporting mechanism in place (Attach Notification & Minutes of the meeting)

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☐ Internal audit system functional (Attach Notification, Audit Report & Minutes of the meeting)

☐ Monthly audit records available (Attach Notification & Audit Report)

Remarks: _____

SECTION 8: CARDIAC OPERATION THEATRE EQUIPMENT (MANDATORY)

☐ Heart–lung machines (minimum 2) Available Quantity :_____

☐ Anesthesia workstation available Available Quantity :_____

☐ Intra-aortic balloon pump (IABP) available Available Quantity :_____

☐ ACT machine available Available Quantity :_____

☐ Defibrillator Available Quantity :_____

☐ Electrocautery unit available Available Quantity :_____

☐ Suction units (minimum 2) Available Quantity :_____

☐ OT lights (minimum 2) Available Quantity :_____

☐ Cardiac operating table available Available Quantity :_____

☐ Temporary pacemaker with leads available Available Quantity :_____

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Remarks: _____

SECTION 9: CCU / ICU EQUIPMENT

☐ Multi-parameter monitors (1 per bed) Available Quantity :_____

☐ Ventilators (≥30% of CCU/ICU beds) Available Quantity :_____

☐ Syringe pumps (minimum 4 per bed) Available Quantity :_____

☐ Defibrillator available in unit Available Quantity :_____

☐ ABG analyzer available in-house Available Quantity :_____

☐ Portable X-ray access Available Quantity :_____

☐ Ultrasound / ECHO access Available Quantity :_____

Remarks: _____

SECTION 10: DIAGNOSTIC & SUPPORT SERVICES

☐ ECG machines (minimum 2) Available Quantity:_____

☐ Echocardiography machines (minimum 1) Available Quantity:_____

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☐ Cardiac catheterization lab (in-house) Available Quantity:_____

☐ CT scan access (in-house or MoU) Available Quantity:_____

☐ Laboratory services functional 24/7

☐ Dialysis machine available (minimum 2) Available Quantity:_____

Remarks: _____

SECTION 11: LIST OF TREATMENT PERFORMED BY THE HOSPITAL

Sr. No	Treatment	Check if provided
1	DVR + TV Repair (With Ring)	
2	CABG + DVR	
3	DVR + TV Repair (Without Ring)	
4	Double Valve Replacement (DVR)	
5	Bentall Procedure (AVR + Aortic Root Replacement)	
6	Aortic Valve Replacement (AVR) – Tissue Valve	
7	Mitral Valve Replacement (MVR) – Tissue Valve	

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8	CABG + AVR	
9	CABG + MVR	
10	AVR + Mitral Valve Repair	
11	MVR + TV Repair	
12	MVR+ Aortic Valve Repair	
13	Valve Surgery + Maze Procedure (AF Surgery)	
14	Aortic Valve Replacement (AVR)	
15	Mitral Valve Replacement (MVR)	
16	CABG + IABP	
17	CABG + Left Ventricular Aneurysm Repair	
18	CABG + Valve Repair	
19	CABG	
20	Partial Anamulous Venous Drainage Repair (PAPVD)	
21	Aortic Root Replacement	
22	Maze Procedure (Standalone)	
23	Acute Type-A Aortic Dissection Repair	
24	Thoracic Aortic Aneurysm Repair (Open)	
25	Ascending Aortic Aneurysm Repair	

CONFIRM THAT

☐ Hospital name, address, and ownership documents are attached

☐ Valid PHC license / registration attached

☐ Valid PBTA & PNRA license attached

☐ NTN / PRA registration attached

☐ Contact person and focal point identified

☐ Copies of licenses and certificates attached

☐ Copies of all relevant documents are attached

☐ Pictures of all relevant sections of the hospital are attached

☐ Pictures of all relevant machines are attached

SIGN & Stamp by Medical Superintendent/CEO/COO/MD

Name: _____ CNIC:_____

Designation: _____

Signature: _____

Date: _____

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Note: Submission of an EOI application does not guarantee empanelment. PHIMC reserves the absolute right, at its sole discretion, to accept or reject any or all EOIs, wholly or partially, without assigning any reason. The empanelment of any hospital shall be undertaken strictly on the basis of program needs, service demand, geographical coverage, population requirements, public sector institutional capacity, and any other parameters as determined by PHIMC.

PHIMC further reserves the right to amend, modify, or withdraw this EOI at any stage without incurring any liability.

Signature & Stamp

PUNJAB HEALTH INITIATIVE MANAGEMENT COMPANY PHIMC