**Health Canada Requirement
(T)Tissue Requirement
Date Format: dd/mmm/yyyy

**TGLN DONOR # _____

TRILLIUM GIFT OF LIFE NETWORK
483 Bay Street South Tower, 4th Floor Toronto, Ontario M5G2C9
Telephone (24/7): 1.877.363.8456
Facsimile: 1.866.557.6100
Website: www.giftoflife.on.ca
Health Canada Regulations #: 100062

ASSESSMENT FORM: ORGAN/COMBINED ORGAN & TISSUE DONOR

REFERRAL

DATE: _____ TIME: _____ PHONE #: _____ EXT: _____ FAX #: _____

HOSPITAL / UNIT: _____ / _____ CONSENT OBTAINED: DATE: _____ TIME: _____

MRN #: _____ OHIP #: _____ DP: _____ OTDC/STAFF: _____

CORONER'S CASE: Y ☐ N ☐ CORONER'S NAME: _____ CORONER'S PHONE #: _____ CONSENT: Y ☐ N ☐

CORONER'S RESTRICTIONS: _____ AUTOPSY PENDING: Y ☐ N ☐ LOCATION: _____

PLANNED DISPOSITION OF UNUSED ORGANS OR TISSUES **(CORONER'S CASE ONLY):** _____

CSC ONLY — NON-ONTARIO OFFER: CANADA ☐ USA ☐ — ADMIN CTO #:

ORGAN(s) OFFERED: _____ DONOR OPO #: _____ **SAF:$** _____ **WAIVERS: Y ☐ N ☐**

OTHER PROGRAMS HAVE DECLINED: Y ☐ N ☐ REASON(s): _____

OTHER ORGANS: _____ OR TIME: _____ HLA: Y ☐ N ☐ SEE REPORT ☐

**DONOR INFORMATION

NAME: _____ AGE: _____

MALE / FEMALE RACE: _____ DOB: _____ (dd/mmm/yyyy)

NDD ☐ DCD ☐ DATE OF DEATH: _____ TIME: _____

CAUSE OF DEATH / DIAGNOSIS: _____

_____ (T)**HT:** _____ CM (T)**WT:** _____ KG

CSC ONLY

ABO: _____ **CSC INITIALS:** _____ / _____

EXCEPTIONAL DISTRIBUTION: Y ☐ N ☐

REASON(s): _____

TLC:_____ (T)**BMI:**_____ **N/A ☐** (T)CROSS CLAMP DATE:_____TIME:_____

**ADMISSION HISTORY

DATE: _____ INTUBATION DATE: _____ TIME: _____

ADMISSION DETAILS: _____

ARRESTS: Y ☐ N ☐ X_____ DATE: _____ TIME: _____ DOWNTIME: _____ CPR / DEFIB / CARDIOVERSION MEDS: _____

TRAUMA / SURGERY: Y ☐ N ☐ _____ **TRANSFUSIONS: Y ☐ N ☐** _____

CHEST TUBES: Y ☐ N ☐ IF YES: R / L / BILATERAL DATE INSERTED: _____ DRAINAGE: _____

DRUG SCREEN DONE YES ☐ NO ☐ SEE REPORT ☐

DATE: _____ TIME: _____ BLOOD / URINE
RESULTS: _____

DATE: _____ TIME: _____ BLOOD / URINE
RESULTS: _____

**PREVIOUS POSITIVE CULTURES YES ☐ NO ☐ SEE REPORT ☐ (T)DOCUMENTED SEPSIS: YES ☐

DATE	TIME	SOURCE	GROWTH	TREATMENT

(T)CSC to TC REPORTING TOOL TISSUE EXCLUSIVE ☐ O/T ☐

(T)For combined organ-tissue cases, CSC – NOTIFY TC OF TISSUE POTENTIAL AS SOON AS HUDDLE COMPLETED

☐ Report given to TC CSC Initials _____ TC Initials _____ Date: _____ Time:_____

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**(T)MEDICATIONS *(Prior to & since admission)* SEE ATTACHED LIST ☐

_____

_____

_____

_____

_____

**SEROLOGY HIGH RISK BEHAVIOUR: YES ☐ NO ☐ IF *YES*, NAT TESTING REQUIRED CSC ONLY

☐ VERBAL ☐ HARDCOPY VERIFIED: _____ / _____ **HLA:** SEE REPORT ☐

	CMV	HbsAG	HIV I + II	HCV	HTLV I + II	HBCAb	Syphilis	WNV (May 1 – Oct 31)	NAT HB	NAT HC	NAT HIV	EBV	TOXO
DONOR UNDILUTED ☐ DILUTED ☐													
MATERNAL REQUIRED: Y ☐ N ☐ UNDILUTED ☐ DILUTED ☐													
SECOND SAMPLE REQUIRED: Y ☐ N ☐ UNDILUTED ☐ DILUTED ☐													

**PAST MEDICAL & SOCIAL HISTORY QUESTIONNAIRE CSC ONLY

(Transcribe positive or unknown results from the Donor Medical & Social History Questionnaire)

(T)MALIGNANCY: Y / N WHEN: _____ TYPE: _____ TREATMENT: _____

REMISSION?: Y / N HOW LONG?_____

(T)DIABETES: Y / N NIDDM / IDDM YEARS: _____ INSULIN / ORAL / DIET (Circle one)

HYPERTENSION: Y / N YEARS: _____ MEDS: SEE MEDICATIONS LIST ☐

DEG. NEURO DISEASES: Y / N IF YES DESCRIBE: _____ YEARS: _____ TREATMENT: _____

INFECT. DISEASES: Y / N IF YES DESCRIBE: _____ YEARS: _____ TREATMENT: _____

SURGERY (prior to admission): Y / N WHEN: _____ TYPE: _____

SMOKING HX: : Y / N AMOUNT: _____ # OF YEARS: _____ QUIT Y / N WHEN: _____

ALCOHOL: Y / N AMOUNT: _____ # OF YEARS: _____ QUIT Y / N WHEN: _____

DRUG ABUSE: Y / N TYPE / ROUTE: _____ # OF YEARS: _____ QUIT Y / N WHEN: _____

ALLERGIES: Y / N IF YES DESCRIBE: _____

ADDITIONAL FINDINGS: _____

_____

_____

_____

_____

**DONOR < 18 MONTHS OR HAS BEEN BREASTFED IN LAST 12 MONTHS YES ☐ NO ☐ CSC ONLY

If *YES*, obtain Maternal Serology & Maternal Medical Social History Questionnaire

MATERNAL NAME: _____ MATERNAL SEROLOGY COLLECTED: Y ☐ N ☐

MATERNAL MEDICAL / SOCIAL HISTORY COMPLETED: Y ☐ N ☐ MATERNAL HEMODILUTION PERFORMED: Y ☐ N ☐ SEE ATTACHED ☐

MATERNAL MEDICAL HISTORY / SOCIAL HISTORY: *(Transcribe positive or unknown results from the Maternal Medical & Social History Questionnaire)*

_____

_____

_____

_____

_____

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**HEMODILUTION CALCULATION #: _____ *(Must be completed with every blood draw)*

Review patients' chart for information about any transfusions 48 hours prior to collection:

- ☐ Yes, all information was reviewed prior to hemodilution calculation.
- ☐ No, all information was not reviewed prior to calculation. Specify why in the clinical notes.

Name: _____ Date: _____ Time: _____

RED BLOOD CELLS containing products infused in the 48-hr period prior to the sample evaluation time. Examples include: whole blood, packed red blood cells, and reconstituted blood.	**COLLOIDS** infused in the 48–hr period prior to the sample evaluation time. Examples include: fresh frozen plasma (FFP), albumin, dextran, pentaspan, platelets, cryoprecipitate and IV Total Parenteral Nutrition (TPN), aka Parenteral Hyperalimentation (PHA)	**CRYSTALLOIDS** infused in the 1-hr period prior to the sample evaluation time. Examples include: saline solution, lactated ringers, propofol, etc. *Mannitol & 3% Saline vol x 3

PRODUCT	VOLUME	PRODUCT	VOLUME	PRODUCT	VOLUME
	A		**B**		**C**

For donors between 45 and 100 kg, use the chart below to calculate the plasma volume (PV) and the blood volume (BV).

Donor Weight (kg) = _____kg

Plasma Volume (PV) = _____ml

Blood Volume (BV) = _____ml

For donors less than 45 kg or greater than 100 kg, use the equations below to calculate the PV and BV:

Donor Weight (kg) Pounds ÷ 2.2 = _____kg

Plasma Volume (PV) = Donor Weight (kg) _____ ÷ 0.025 = _____ml

Blood Volume (BV) = Donor Weight (kg) _____ ÷ 0.015 = _____ml

CALCULATION TABLE (Round all weights down)

kg	PV	BV	kg	PV	BV	kg	PV	BV	kg	PV	BV
45	1800	3000	**59**	2360	3933	**73**	2920	4867	**87**	3480	5800
46	1840	3067	**60**	2400	4000	**74**	2960	4933	**88**	3520	5867
47	1880	3133	**61**	2440	4067	**75**	3000	5000	**89**	3560	5933
48	1920	3200	**62**	2480	4133	**76**	3040	5067	**90**	3600	6000
49	1960	3267	**63**	2520	4200	**77**	3080	5133	**91**	3640	6067
50	2000	3333	**64**	2560	4267	**78**	3120	5200	**92**	3680	6133
51	2040	3400	**65**	2600	4333	**79**	3160	5267	**93**	3720	6200
52	2080	3467	**66**	2640	4400	**80**	3200	5333	**94**	3760	6267
53	2120	3533	**67**	2680	4467	**81**	3240	5400	**95**	3800	6333
54	2160	3600	**68**	2720	4533	**82**	3280	5467	**96**	3840	6400
55	2200	3667	**69**	2760	4600	**83**	3320	5533	**97**	3880	6467
56	2240	3733	**70**	2800	4667	**84**	3360	5600	**98**	3920	6533
57	2280	3800	**71**	2840	4733	**85**	3400	5667	**99**	3960	6600
58	2320	3867	**72**	2880	4800	**86**	3440	5733	**100**	4000	6667

ENSURE HEMODILUTION CALCULATION IS COMPLETED FOR SAMPLES BEING DRAWN IN THE OR (i.e.: PHL sample / archival)

Sample Acceptability Disposition

Total from B + C = _____ml

Is this value greater than the plasma volume? Y / N

Total from A + B + C _____ml

Is this value greater than the blood volume? Y / N

Calculation performed by: _____Date: _____Time: _____

IF THE ANSWER TO BOTH QUESTIONS IS **"NO,"** THE SAMPLE IS ACCEPTABLE FOR TESTING

IF THE ANSWER TO EITHER QUESTION IS **"YES,"** THE SAMPLE IS EXCESSIVELY DILUTED; ATTEMPT TO OBTAIN STORED SAMPLE FOR TESTING

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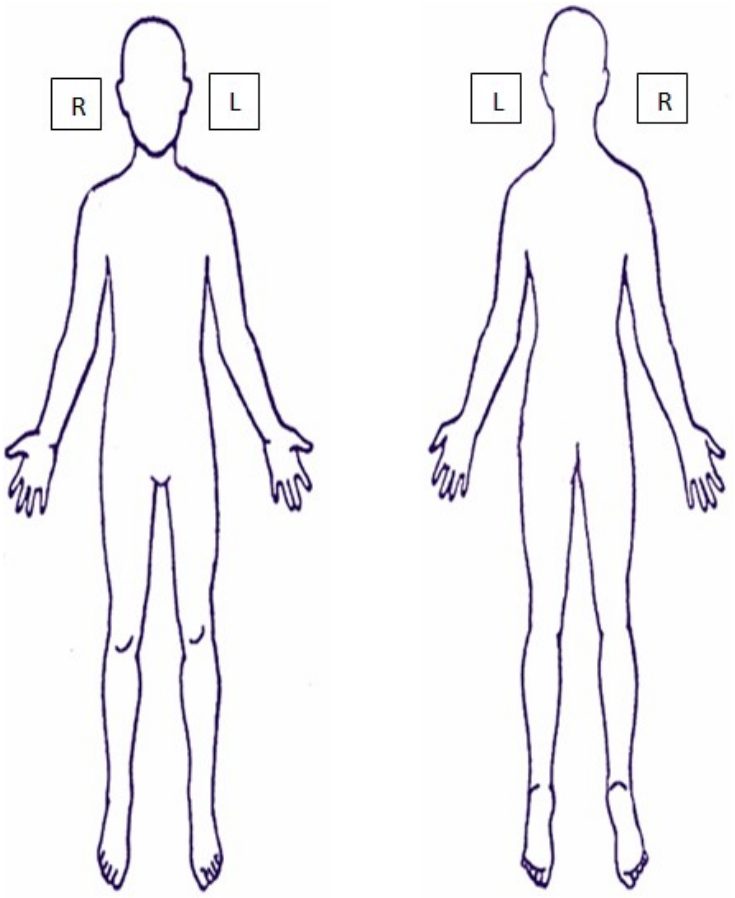
**PHYSICAL ASSESSMENT

Inspection Completed:

☐ Front Comments: _____

☐ Back Comments: _____



Key to Schematic

A – Abrasion	J - TGLN Blood Collection Site	S – Tattoo Description
B – Bruise / Contusion	K – Endotracheal Tube	T – Intracranial Monitor / Ventriculostomy
C – Chest Tube	L – Laceration	U – Lividity
D – Defibrillator Marks	M – Lesion	V – Fracture/Dislocation
E – Piercing	N – Needle Entry Site	( ) _____
F – Foley Catheter	O – Cast or Splint	( ) _____
G – Oral / Nasal Gastric Tube	P – Bandaged Area	( ) _____
H – Hematoma	Q – Hospital ID Band	( ) _____
I – I.V. / Arterial Line	R – Scar	( ) _____

Is there evidence of:

Jaundice	No	Yes
Genital Lesions	No	Yes
Palpable Masses	No	Yes
Enlarged Lymph Nodes	No	Yes
Tattoo	No	Yes
Piercing	No	Yes
White spots in mouth	No	Yes
Non-Medical Injection sites	No	Yes
Insertion Trauma/Perianal lesions	No	Yes
Rash/scab/skin Lesion (non-genital)	No	Yes
Blue/Purple (gray/black) Spots/Lesions	No	Yes
Trauma or infection to the retrieval site	No	Yes
Abnormal Ocular finding (icterus/scarring)	No	Yes

Physical examination included inspection of donor for physical evidence of: sexually transmitted disease (such as genital ulcerative disease, herpes simplex, syphilis, chancroid), anal intercourse including perianal condyloma, non-medical percutaneous drug use (such as needle tracks), disseminated lymphadenopathy, oral thrush, blue or purple spots consistent with Kaposi's sarcoma, needle tracks (including examination of tattoos), unexplained jaundice, or icterus.

Physical Exam done by : _____
OTDC or qualified designate Signature

Date: _____/_____/_____ @ _____Hrs
DD MMM YYYY 0000

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**HEMODYNAMICS

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BLOOD PRESSURE TYPE	DATE	TIME	B / P	EPISODES	DURATION	TREATMENT
HYPOTENSION: Y ☐ N ☐						
HYPERTENSION: Y ☐ N ☐						

HEMODYNAMIC PROFILE								
(T)DATE _____ yyyy								
(T)TIME								
B / P								
MAP								
HR								
CVP / PCWP								
(T)TEMP								
SpO_2 / SaO_2								
MAINTENANCE IV (mL / hr)								
OTHER IV (mL / hr)								
(T)BLOOD PRODUCTS (mL)								
(T)IV BOLUS (mL)								
MEDICATION								
VASOPRESSIN started @ (units / hr) (mL/ hr)								
DRUG TYPE: VOLUME: (mL / hr)								
DRUG TYPE: VOLUME: (mL / hr)								
INSULIN (units) (mL/ hr)								
ELECTROLYTE REPLACEMENT (mL)								
(T)ANTIBIOTICS (mL)								
T4 (µg) (mL)								
SOLUMEDROL (mL/ kg) (mL)								
PRN Meds IV (mL)								
OTHER: (mL)								
OTHER: (mL)								
TOTAL IV								
U / O (MIN=0.5-3 ml/ kg / hr)								
OTHER: (mL)								
OTHER: (mL)								
TOTAL OUT								

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**LABORATORY DATA

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		ADMISSION								
	DATE _____ YYYY									
	TIME									
ELECTROLYTES	Na (135-147 mmol/L)									
	K (3.5-5.0 mmol/L)									
	Cl (96-106 mmol/L)									
	Bicarb (21 – 28)									
	Urea (3.0 – 7.0 mmol/L)									
	Cr (M 50 – 90 u mol/L) (F 30 – 80 u mol/L)									
	Glu (4.0 – 6.0mmol/L)									
	HgbA1c (4.0 – 5.9 %)									
	Ca (2.20 – 2.60 mmol/L)									
	Mg (0.70 – 1.10 mmol/L)									
	Phos (0.80 – 1.40 mmol/L)									
	Lactate									
LIVER PROFILE	Total Bili (4 – 20 mmol/L)									
	Direct Bili (0 – 3 mmol/L)									
	AST (SGOT) (<36 u/L)									
	ALT (SGPT) (< 50 u/L)									
	ALP (<80 u/L)									
	LDH (90 – 190 u/L)									
	Total Protein (65 – 80 g/L)									
	Albumin (38 – 50 g/L)									
	Amylase (100 u/L)									
	Lipase									
	GGT (0- 30 u/L)									
CARDIAC	CK (M <255 u/L) (F <150 u/L)									
	CK – MB (<10 u/L)									
	Troponin T (<0.10 ug/L)									
	Troponin I (<0.07 ug/L)									
COAG	PT (9 – 11.5)									
	PTT (24 – 36)									
	INR									
HEMATOLOGY	(T)WCT (4 – 11 10^6/L)									
	PLATELETS (150-350 10^6/L)									
	HEMAGLOBIN (M 140 – 180) (F 120 – 160)									
	HEMATOCRIT (M 0.42 – 0.52) (F 0.37 – 0.47)									
	RBC (M 4.5 – 5.3) (F 4.1 – 5.1)									

**ROUTINE CULTURES

INITIAL ROUTINE CULTURE: (T)BLOOD ☐ (T)SPUTUM ☐ (T)URINE ☐ OTHER: _____ DATE: _____ TIME: ____

REPEAT CULTURES (Q24h): Y ☐ N ☐ BLOOD ☐ SPUTUM ☐ URINE ☐ OTHER: _____ DATE: _____ TIME: ____

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HEART PROFILE

DIAGNOSTIC TEST	HARDCOPY – HC VERBAL – V EMAIL – E	DATE (dd/mmm/yyyy)	TIME	RESULTS (If HC present, see report)
**12 LEAD ECG (Please have read at donor site)				
**1ST ECHO				
2ND ECHO Y ☐ N ☐				
ANGIO Y ☐ N ☐ (See Angio Algorithm) (S:\Provincial Resource Centre\Processes and Checklist)				

QUALITY ONLY: HEART TRANSPLANTED ☐

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LUNG PROFILE

BLOOD GASES **CHALLENGE ABGs TO BE DONE ON 100% FiO_2 x 10 MINUTES								
DATE ____ YYYY								
TIME								
PH								
PCO_2								
HCO_3								
**pO_2								
RECRUITMENT (30 PEEP x 30 seconds)								
VENTILATOR SETTINGS								
VENT MODE								
RR	SET / ACTUAL							
VT	SET / ACTUAL							
PEEP								
PP								
FiO_2								

TOTAL LUNG CAPACITY (TLC) CALCULATION:
MALES: (0.09 x HT) – 8.618 FEMALES: (0.071 x HT) – (0.007 x AGE) – 5.965

DIAGNOSTIC TEST	HARDCOPY – HC VERBAL – V EMAIL – E	DATE (dd/mmm/yyyy)	TIME	RESULTS (If HC present, see report)
**(T)1st CXR (Mandatory for All Donors)	HC / V (Mandatory HC/ V)			
2nd CXR Y ☐ N ☐				
3rd CXR Y ☐ N ☐				
4th CXR Y ☐ N ☐				
**1st BRONCH				
2nd BRONCH Y ☐ N ☐				
CHEST CT Y ☐ N ☐				

BRONCHIAL ASPIRATION LAVAGE (BAL) COLLECTED FOR GRAM STAIN: **Y☐ **N**☐

CHEST CIRCUMFERENCE IF REQUIRED **Y**☐ **N**☐ _____ CM

QUALITY ONLY: LUNGS TRANSPLANTED ☐

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ABDOMINAL PROFILE

DIAGNOSTIC TEST	HARDCOPY – HC VERBAL – V	DATE (dd/mmm/yyyy)	TIME	RESULTS (If HC present, see report)
ABDOMINAL CT Y ☐ N ☐				
ABDOMINAL U / S Y ☐ N ☐				
LIVER BIOPSY Y ☐ N ☐				

ABDOMINAL GIRTH REQUIRED: Y☐ N☐ _____ CM

BOWEL PREP REQUIRED: Y☐ N☐

Who Ordered: _____

What Ordered:

_____ Given: Date _____ Time:_____

_____ Given: Date _____ Time:_____

_____ Given: Date _____ Time:_____

_____ Given: Date _____ Time:_____

QUALITY ONLY:	
LIVER TRANSPLANTED	
KIDNEYS TRANSPLANTED	
PANCREAS TRANSPLANTED	
SMALL BOWEL TRANSPLANTED	
STOMACH TRANSPLANTED	

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KIDNEY / PANCREAS PROFILE

CSC ONLY GLOMULAR FILTRATION RATE (GFR) / CREATININE CLEARANCE (CrCl)

PLEASE USE THE FOLLOWING WEBSITE TO CALCULATE THE **GFR**:

Adults - http://www.renal.org/eGFRcalc/GFR.pl

Paediatrics - http://www.kidney.org/professionals/kdoqi/gfr_calculatorPed.cfm

Creatinine Clearance Formula:

(140 – AGE) (WEIGHT IN KG) X 60 (0.85 FOR WOMAN ONLY)

(50 x MOST RECENT SERUM CREATININE)

DATE _____ YYYY									
TIME									
** CREATININE									
eGFR									
CrCl									

ECD DONOR: Y ☐ N ☐ ENTERED IN THE DATABASE? Y ☐ N ☐

**URINALYSIS

DATE _____ YYYY			
TIME			
	R&M / DIPSTICK	R&M / DIPSTICK	R&M / DIPSTICK
PH			
SPECIFIC GRAVITY			
GLUCOSE			
PROTEIN			
KETONE			
BLOOD			
WBC			
RBC			
NITRATES			

DIAGNOSTIC TEST	HARDCOPY – HC VERBAL – V	DATE (dd/mmm/yyyy)	TIME	RESULTS (If HC present, see report)
KIDNEY U / S Y ☐ N ☐				
KIDNEY BIOPSY Y ☐ N ☐ WHO: _____ WHERE: _____				

QUALITY ONLY:	KIDNEYS TRANSPLANTED	
	PANCREAS TRANSPLANTED	

**TGLN DONOR # ____________________

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DATE	TIME	CLINICAL NOTES	INT.

Coordinator Signature: ______________________________ Coordinator Signature: ______________________________

Coordinator Signature: ______________________________ Coordinator Signature: ______________________________

Coordinator Signature: ______________________________ Coordinator Signature: ______________________________

**TGLN DONOR # ____________________

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DATE	TIME	CLINICAL NOTES	INT.

Coordinator Signature: ________________________________ Coordinator Signature: ________________________________

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DATE	TIME	CLINICAL NOTES	INT.

Coordinator Signature: ___________________________ Coordinator Signature: ___________________________

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DATE	TIME	CLINICAL NOTES	INT.

Coordinator Signature: ________________________ Coordinator Signature: ________________________

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Coordinator Signature: ________________________ Coordinator Signature: ________________________

**HEMODYNAMICS

**TGLN DONOR # _____

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HEMODYNAMIC PROFILE								
(T)DATE _____ YYYY								
(T)TIME								
B / P								
MAP								
HR								
CVP / PCWP								
(T)TEMP								
SpO_2 / SaO_2								
MAINTENANCE IV (mL / hr)								
OTHER IV (mL / hr)								
(T)BLOOD PRODUCTS (mL)								
(T)IV BOLUS (mL)								
MEDICATION								
VASOPRESSIN started @ (units / hr) (mL/ hr)								
DRUG TYPE: VOLUME: (mL / hr)								
DRUG TYPE: VOLUME: (mL / hr)								
INSULIN (units) (mL/ hr)								
ELECTROLYTE REPLACEMENT (mL)								
(T)ANTIBIOTICS (mL)								
T4 (µg) (mL)								
SOLUMEDROL (mL/ kg) (mL)								
PRN Meds IV (mL)								
OTHER: (mL)								
OTHER: (mL)								
TOTAL IV								
U / O (MIN=0.5-3 ml/ kg / hr)								
OTHER: (mL)								
OTHER: (mL)								
TOTAL OUT								

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	DATE _____ (YYYY)									
	TIME									
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	K (3.5-5.0 mmol/L)									
	Cl (96-106 mmol/L)									
	Bicarb (21 – 28)									
	Urea (3.0 – 7.0 mmol/L)									
	Cr (M 50 – 90 u mol/L) (F 30 – 80 u mol/L)									
	Glu (4.0 – 6.0mmol/L)									
	HgbA1c (4.0 – 5.9 %)									
	Ca (2.20 – 2.60 mmol/L)									
	Mg (0.70 – 1.10 mmol/L)									
	Phos (0.80 – 1.40 mmol/L)									
	Lactate									
LIVER PROFILE	Total Bili (4 – 20 mmol/L)									
	Direct Bili (0 – 3 mmol/L)									
	AST (SGOT) (<36 u/L)									
	ALT (SGPT) (< 50 u/L)									
	ALP (<80 u/L)									
	LDH (90 – 190 u/L)									
	Total Protein (65 – 80 g/L)									
	Albumin (38 – 50 g/L)									
	Amylase (100 u/L)									
	Lipase									
	GGT (0- 30 u/L)									
CARDIAC	CK (M <255 u/L) (F <150 u/L)									
	CK – MB (<10 u/L)									
	Troponin T (<0.10 ug/L)									
	Troponin I (<0.07 ug/L)									
COAG	PT (9 – 11.5)									
	PTT (24 – 36)									
	INR									
HEMATOLOGY	(T)WCT (4 – 11 10^6/L)									
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	HEMAGLOBIN (M 140 – 180) (F 120 – 160)									
	HEMATOCRIT (M 0.42 – 0.52) (F 0.37 – 0.47)									
	RBC (M 4.5 – 5.3) (F 4.1 – 5.1)									

Echocardiogram WORKSHEET

Date: _____ Time: _____

Inotropes (During the Exam) (mcg/kg/min):

Levophed	_____	Vasopressin	_____
Dobutamine	_____	Epinephrine	_____
Dopamine	_____	Other _____	_____

Pulmonary Pressure: _____mmHg

T4 Given: ☐ Yes ☐ No
If yes, amount _____ Time: _____

CVP _____mmHg

Atrium:

LA Dimension _____cm2 RA Dimension _____cm2

ASD ☐ Present ☐ Absent

PFO ☐ Present ☐ Absent

Right Ventricle:

Contractility ☐ Normal ☐ Moderate Hypokinesis ☐ Severe Hypokinesis

Tricuspid Regurgitation □ I □ II □ III □ IV

RVSP/Pulmonary Pressure: _____mmHg

Left Ventricle:

Ejection Fraction _____%

Shortening Fraction _____%

Contractility ☐ Normal ☐ Moderate Hypokinesis ☐ Severe Hypokinesis

Regional WMA ☐ anterior □ apical □ lateral □ inferior □ posterior ☐ septal

LVEDD _____mm

LVESD _____mm

Septal Thickness _____mm

Post Wall Thickness_____mm

Left Ventricular Hypertrophy ☐ Present ☐ Absent

Aortic Valve:

☐ Normal ☐ Sclerotic ☐Stenosis ☐ Bicuspid

Aortic Valve gradient _____ AVA_____

Aortic Regurgitation □ I □ II □ III □ IV

Mitral Valve:

☐ Normal ☐ Sclerotic ☐Stenosis ☐ Bicuspid

Mitral Regurgitation □ I □ II □ III □ IV

MItral Annular Calcification ☐ mild ☐ Moderate ☐ Severe

Any Additional Comments:

_____

_____

Name: _____ Status: _____ Affiliation: _____ Signature: _____

**TGLN DONOR # _____

**Health Canada Requirement
(T)Tissue Requirement

Date Format: dd/mmm/yyyy

BRONCHOSCOPY WORKSHEET

Date: _____ Time: _____

Description	LEFT	RIGHT	N/A	Comments
Anatomy: Normal Abnormal	 ☐ ☐	 ☐ ☐		If abnormal, please describe findings:
Secretions:			☐	
Bloody Secretions: Mild Moderate Severe Reaccumulation after suctioning	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	☐	
Mucoid Secretions: Mild Moderate Severe Reaccumulation after suctioning	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	☐	
Purulent Secretions: Mild Moderate Severe Reaccumulation after suctioning	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	☐	
Airway Erythema:	☐	☐	☐	If yes, please describe below:
Obvious Aspiration:	☐	☐	☐	
BAL Sent:	☐	☐	☐	Gram Stain Results:

Any Additional Comments:

_____

_____

Physician who interpreted and reported results: _____

Signature: _____ Status (i.e. resident): _____ Hospital: _____

Name: _____

**TGLN DONOR # _____

**Health Canada Requirement
(T)Tissue Requirement

Date Format: dd/mmm/yyyy

OTDC WORKSHEET

CONTACT INFORMATION						
NAME	HOSPITAL	ADDRESS	PHONE	EXT	PAGER	FAX

OHIP – WISHES REGISTERED: Y ☐ N ☐ PROVIDED TO FAMILY: Y ☐ N ☐

DCD EVALUATION Y ☐ N ☐ DCD EVALUATION PROBABILITY: HIGH/MEDIUM/LOW-SCORE:_____

PLAN TO WDLS: DATE: _____ TIME:_____

MINIMUM TESTING REQUIREMENTS FOR ALL ORGAN DONORS							
HEIGHT, WEIGHT		COMPLETE BLOOD COUNT		CONSENT		HEMODILUTION CALCULATION	
ABO		CREATININE		NDD		HEMODYNAMIC PROFILE	
ELECTROLYTES		CHEST X-RAY		MED-SOC HX		CULTURE RESULTS (if any)	

SEROLOGY
SPECIMAN COLLECTED DATE_____@_____ HAND-OFF:_____

ORGAN SPECIFIC TESTING		
LIVER	LFT'S (TOTAL BILIRUBIN, AST, ALT, ALP) LDH, AMYLASE, GGT, PT/INR, PTT, CBC	
LIVER/BOWEL	LFT'S (TOTAL BILIRUBIN, AST, ALT, ALP) LDH, AMYLASE, GGT. PT/INR, PTT, CBC & LIVER/BOWEL ANTIBIOTIC COCKTAIL	
HEART	12 LEAD ECG, 2D ECHO, TROPONIN, CK, CK-MB, CXR	
LUNG	ABG'S (1.0 Fi02, PEEP 8-10 x 10 MIN, Q2HR), CXR – Q4HR, SPUTUM CULTURE, SUCTIONING, BRONCHOSCOPY, MOST RECENT CXR, 100% ABG'S AVAILABLE IN OR, 1 GM SOLUMEDROL	
KIDNEY	ELECTROLYTES, CREATININE, UREA, URINALYSIS, URINE OUTPUT, BLOOD & URINE CULTURES	
KIDNEY/PANCREAS	KIDNEY TESTS, AMYLASE, LIPASE, GLUCOSE, CREATININE CLEARANCE	

**TGLN DONOR # _____

**Health Canada Requirement
(T)Tissue Requirement

Date Format: dd/mmm/yyyy

CSC WORKSHEET

CONTACT INFORMATION

NAME	HOSPITAL	ADDRESS	PHONE	EXT	PAGER	FAX

CONSENT

CONSENT OBTAINED Y / N DATE: _____TIME:_____

PRE-MORTEM CONSENT (DCD) Y / N DATE: _____TIME: _____

NAME OF PATIENTS SUBSTITUTE: _____ RELATIONSHIP: _____

☐ **Option 1: ALL organ(s) and tissue(s) listed below.**	☐ **Option 2: ONLY the organ(s) and/or tissue(s) checked ☑ in the box below.**

☐ HEART ☐ SMALL BOWEL ☐ PANCREAS ☐ PANCREAS FOR ISLETS ☐ SKIN

☐ LUNGS ☐ STOMACH ☐ HEART FOR VALVES; PERICARDIUM; AORTA ☐ VESSEL

☐ KIDNEYS ☐ LIVER ☐ BONE AND CONNECTIVE TISSUE ☐ EYES/ ____CORNEAS ONLY

☐ **SCIENTIFIC RESEARCH AND MEDICAL**	☐ **SCIENTIFIC RESEARCH ONLY**	☐ **MEDICAL EDUCATION ONLY**	☐ **NEITHER**

DCD EVALUATION Y ☐ N ☐ DCD EVALUATION PROBABILITY: HIGH/MEDIUM/LOW-SCORE:_____

PLAN TO WDLS: DATE: _____ TIME:_____

KIDNEY PUMPS USED: Y ☐ N ☐

MINIMUM TESTING REQUIREMENTS FOR ALL ORGAN DONORS

HEIGHT, WEIGHT		**COMPLETE BLOOD COUNT**		**CONSENT**		**HEMODILUTION CALCULATION**	
ABO		**CREATININE**		**NDD**		**HEMODYNAMIC PROFILE**	
ELECTROLYTES		**CHEST X-RAY**		**MED-SOC HX**		**CULTURE RESULTS (if any)**	

SEROLOGY AND HLA

SPECIMAN COLLECTED DATE_____@_____ ETA TO HLA LAB_____ SAMPLE RECEIVED @_____ RESULTS ETA_____
ETA TO SERO LAB_____ SAMPLE RECEIVED @_____ RESULTS ETA_____

ORGAN SPECIFIC TESTING

LIVER	LFT'S (TOTAL BILIRUBIN, AST, ALT, ALP) LDH, AMYLASE, GGT, PT/INR, PTT, CBC	
LIVER/BOWEL	LFT'S (TOTAL BILIRUBIN, AST, ALT, ALP) LDH, AMYLASE, GGT. PT/INR, PTT, CBC & LIVER/BOWEL ANTIBIOTIC COCKTAIL	
HEART	12 LEAD ECG, 2D ECHO, TROPONIN, CK, CK-MB, CXR	
LUNG	ABG'S (1.0 Fi02, PEEP 8-10 x 10 MIN, Q2HR), CXR – Q4HR, SPUTUM CULTURE, SUCTIONING, BRONCHOSCOPY, MOST RECENT CXR, 100% ABG'S AVAILABLE IN OR, 1 GM SOLUMEDROL	
KIDNEY	ELECTROLYTES, CREATININE, UREA, URINALYSIS, URINE OUTPUT, BLOOD & URINE CULTURES	
KIDNEY/PANCREAS	KIDNEY TESTS, AMYLASE, LIPASE, GLUCOSE, CREATININE CLEARANCE	

**TGLN DONOR # _____

**Health Canada Requirement
(T)Tissue Requirement

Date Format: dd/mmm/yyyy

TRANSPORTATION – CSC ONLY

DONOR HOSPITAL: _____

ADDRESS: _____

ON-SITE OTDC: _____ PAGER #: _____ CSC: _____

SRC: _____ TIME SRC NOTIFIED: _____ TIME TO BE IN OFFICE:_____ RECOVERY TEAM PICK UP TIME:_____

AIR AMBULANCE

CALL: 1-800-387-4672 SPOKE WITH INTAKE: _____ DATE: _____ TIME: _____

DETAILS

SPOKE WITH FLIGHT FOLLOWING: _____ TIME: _____ CONFIRMATION #: _____

DETAILS PROVIDED BY TGLN: DEPARTURE DATE: _____ TIME: _____ ☐ DONOR TGLN #: _____

☐ NUMBER OF PLANES: _____ ☐ ORGANS BEING RECOVERED: _____ ☐ DESTINATION HOSPITAL: _____

☐ RECIPIENT OHIP #: _____ ☐ RECIPIENT TGLN #: _____

☐ NUMBER OF TEAM MEMBERS: _____ ☐ PASSPORT NUMBER: _____ ☐ Weights: _____ ☐ Meals Requested (both ways)

☐ EXECUTIVELY CONFIGURED OR OTHER: _____ ☐ EQUIPMENT BEING BROUGHT: _____

TEAM MEMBERS: (FULL NAME, DOB, WT, PASSPORT INFO AND VISA #)

HEART: # OF TEAM MEMBERS: _____ NAMES: _____

LUNGS: # OF TEAM MEMBERS: _____ NAMES: _____

LIVER/KIDNEY: # OF TEAM MEMBERS: _____ NAMES: _____

PANCREAS: # OF TEAM MEMBERS: _____ NAMES: _____

TRANSPORTATION DETAILS

TEAM #1

DEPARTURE: AIRPORT: _____ HANGER: _____ COMPANY: _____ TAIL #: _____ FLIGHT #: _____

PILOTS DUTY TIME ENDS AT: _____ EXPECTED TIME ON THE GROUND: _____

ARRIVAL: - DONOR CITY: _____ ETA: _____ AIRPORT NAME: _____ FBO: _____

GROUND TRANSPORTATION: _____ ARRANGED BY: _____

DEPARTURE: - DONOR CITY: _____ETA: _____ AIRPORT NAME: _____ FBO: _____

GROUND TRANSPORTATION: _____ ARRANGED BY: _____

ARRIVAL RECIP CITY: _____ ETA: _____ AIRPORT NAME: _____ FBO: _____

GROUND TRANSPORTATION: _____ ARRANGED BY: _____

TEAM #2

DEPARTURE: AIRPORT: _____ HANGER: _____ COMPANY: _____ TAIL #: _____ FLIGHT #: _____

PILOTS DUTY TIME ENDS AT: _____ EXPECTED TIME ON THE GROUND: _____

ARRIVAL: - DONOR CITY: _____ ETA: _____ AIRPORT NAME: _____ FBO: _____

GROUND TRANSPORTATION: _____ ARRANGED BY: _____

DEPARTURE: - DONOR CITY: _____ETA: _____ AIRPORT NAME: _____ FBO: _____

GROUND TRANSPORTATION: _____ ARRANGED BY: _____

ARRIVAL RECIP CITY: _____ ETA: _____ AIRPORT NAME: _____ FBO: _____

GROUND TRANSPORTATION: _____ ARRANGED BY: _____

If both thoracic and abdominal organs are being recovered, 2 return flights will be necessary. If heart and lungs are being recovered, check with both teams re: separate return flights.
Obtain estimated times from ORNGE and relay this to the transplant programs

*Ensure all delays are communicated with transplant programs / ROCC / LHSC TC

**TGLN DONOR # _____

**Health Canada Requirement
(T)Tissue Requirement

Date Format: dd/mmm/yyyy

DONOR TRANSFER CALL: 1-866-869-7822 then press 1

SPOKE WITH INTAKE: _____ TIME: _____

☐ Need to obtain MTO number prior to transfer (forms located at 7802 desk: complete and fax to: 1-866-302-5262)

MTO #: _____

Metro Ambulance: 416-638-7301 North of GTA Ambulance: 705-756-8103 Hamilton Ambulance: 1-800-263-5767

OPP CALL: 1-888-310-1122

SPOKE WITH INTAKE: _____ TIME: _____

Details Provided by TGLN:

☐ What is being transported _____ ☐ Lights and sirens

☐ Where is specimen to be picked up _____ Time: _____

☐ Contact person sending and receiving – Name: _____ Number: _____

☐ Delivery address _____

☐ Kingston OPP: 1-613-384-2406 ☐ Metro Police: 416-808-2222 ☐ Peel Police: 905-453-3311

** Hamilton Marine Police Unit: 1-905-546-4941 (Seasonal-will transport specimens & teams)

* Police will transport specimens and organs / will usually not transport teams

Air Canada Med Desk CALL: 1-800-667-4732 (08:00-20:00) OR 1-506-637-2469 (after hours)

SPOKE WITH INTAKE: _____ TIME: _____ **Account Number: 8773638456**

Details Provided by TGLN:

☐ Flight Number _____

☐ Which organ (s) _____ ☐ Time organ will be at counter _____

☐ Individual who will be dropping off organ _____ ☐ ETA of Flight (EST) _____

☐ Receiving program and contact name and number _____

* Be sure to complete *Transportation of Organ for Emergency Transplant form* to accompany organ & serology & ABO

** Usually used for organs i.e. Pancreas for islets

Air Canada Cargo CALL: 905-694-5300 x 3100 (Between 07:00-22:00)

SPOKE WITH INTAKE: _____ TIME: _____ **Account Number: 930366**

Details Provided by TGLN:

☐ Flight Number _____

☐ Which organ (s) _____ ☐ Way Bill # _____ ☐ Time organ will be at counter _____

☐ Individual who will be dropping off organ – Name: _____ Contact Number: _____

☐ ETA of Flight (EST) _____

☐ Receiving program: _____ Contact Name: _____ Contact Number: _____

* Be sure to complete *Transportation of Organ for Emergency Transplant form* to accompany organ & serology & ABO

** Usually used for transporting blood samples. DO NOT SEND ORGANS VIA CARGO

Taxis / Limos

Toronto:	Royal Taxi:	416-777-0039	Account # 20298 (used for specimens)
	Coop Taxi:	416-504-2667	Account # 50233 (used for specimens)
	Culliton Limo:	416-495-1900	Account # TRIGIFOO (used for teams only) (Give them donor TGLN # for PO number)
London:	Checker Limo:	1-519-659-0400	Account # 293501 (used for teams to & from airport) (Give them donor TGLN #)
Ottawa:	Accuro courier service:	1-613-738-1242	Account # A01505 (used for delivery or p/u of organs at the airport) (Three employees with Ottawa Hospital ID: Geoff Simpson, Chris Cheeseman, Shawn Frazier)

**TGLN DONOR # _____

**Health Canada Requirement
(T)Tissue Requirement

Date Format: dd/mmm/yyyy

CASE FOLLOW UP REPORT

Provincial Resource Centre

Date of Refer: _____ / _____ / _____ **Hospital Region:** _____ **Unit:** _____
dd mmm yyyy

TGLN COORDINATOR: (Intake Coordinator): _____ (Case Manager): _____

(Surgical Recovery Coordinator): _____ (Other): _____

Case Analysis: Brief description of important issues

Learning Opportunities

Follow-up