

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

Final
Outcome:
Donor
□Non-donor

Assessment Form - Tissue Donor

Referral (from database)	
TGLN #: Date at	nd Time:/ @hours
Hospital/floor:	_Ref'd From: Phone:
Coordinator(s):	DP: Exceptions:
Donor Name:	
Last Name, First Name OHIP #:	/ Version Code:
	/ TOD: Date of Admission:/
Case Coordination	
Detailed COD:	Fax #:
	Time Transferred to Morgue: Family Notified: □No □Yes
	Relationship: Phone:
Family Contact #2:	Relationship: Phone:
Coroner's Case: No Yes Name of Coroner:	Phone #:
Coroner Consent: No Yes Restrictions:	
	Phone #:
Attending Physician:	or
Family Physician:	or 🗖 N/A R&T Phone #:
Admission History	
If VSA, time last seen/heard from:	Intubated Sno Syes if Yes, Date:/ @Hrs Duration:
Medical History	
Details:	
Diabetes: ☐No ☐Yes if Yes, ☐Type1 ☐Type 2 #Years: _	Meds:
Cancer: No Yes if Yes, type:	
Donor Height: ☐Actual ☐Estimated	
Blood Work □N/A R&T	Temperature □N/A R&T
Date Time WBC	Date Time °C
Blood Cultures	Results:
Multi-Tissue Potential	
Sputum Cultures	Results:
Urine Cultures	Results:
CXR	Results:
	Results.
Antibiotics	Type(s):

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Current Medications:							
_ Current Chart location: □	Physical Chart located at		□ Electronic	Chart accessed by:			
Hemodilution Calcula		•	BElectionic	Chart accessed by:			
		? □No □Yes if Yes,	Departure Date:	// Time	:		
Did patient arrive via ar	•		-	/ Time:			
Were fluids administere	ed at admission?	□No □Yes					
prior to blood collection	/death, and the total c	rovided the total volume rystalloids infused in the Date:	1 hour prior to bloo	od collection/death:	d colloids in the 48 hours		
					hours or Inot applicable		
A Red Blood Cell		B Colloids infused			infused in the 1-hour period		
infused in the 48-hour sample evaluation time	period prior to the	prior to sample evalua	ation time. Example	les prior to the sampl	e evaluation time. Examples		
whole blood, packed r		include: plasma, Pentaspan, platelets, o		IV *Mannitol & 3% S	utions, lactated ringers etc. aline volume X 3		
reconstituted blood.		Total Parenteral Nutriti Hyperalimentation (PH		eral			
Product	Volume	Product	Volume	Product	Volume		
Please note: If the do	nor weight is greate	r than 100 kg, use the l	PV and BV values	for 100 kg.			
☐ Method 1: For donor	s between 45 and 100) kg, use the chart	☐ Method 2: For	donors less than 45 kg	, use the equations below to		
below to calculate the p		_	calculate the PV		•		
Donor Weight (kg) =		_kg	Donor Weight (p	oounds ÷ 2.2) =	kg		
Plasma Volume (PV) =		_ml	Plasma Volume =	= Donor weight (kg)	÷ 0.025 =ml		
Blood Volume (BV) =		_ml	Blood Volume = I	Donor weight (kg)	÷ 0.015 =ml		
Calculation Table (round all weights down)							
kg PV B 45 1800 30	V kg 00 59	PV BV 2360 3933	kg PV 73 2920	BV kg 4867 87	PV BV 3480 5800		
46 1840 30	67 60	2400 4000	74 2960	4933 88	3520 5867		
47 1880 31 48 1920 32		2440 4067 2480 4133		5000 89 5067 90	3560 5933 3600 6000		
49 1960 32		2520 4200		5133 91	3640 6067		
50 2000 33		2560 4267		5200 92	3680 6133		
51 2040 34 52 2080 34		2600 4333 2640 4400		5267 5333 93	3720 6200 3760 6267		
53 2120 35	33 67	2680 4467	81 3240	5400 95	3800 6333		
54 2160 36 55 2200 36		2720 4533 2760 4600		5467 96 5533 97	3840 6400 3880 6467		
56 2240 37	70	2800 4667	84 3360	5600 98	3920 6533		
57 2280 38 58 2320 38		2840 4733 2880 4800		5667 99 5733 100	3960 6600 4000 6667		
Sample Acceptability Determination							
Total from B + C =		-	than the plasma vo		□ No		
Total from A + B + C =	ml	Is this greater	than the blood volu	ume?	□ No		

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	amala Arrallalala	□Yes □No Location/Department:	
ernate Sa be of Tub	ample Available: ses and Amounts	::	
Date	Time	Clinical Notes	Initials

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	Tissue Accepte	d						
Skin:	Eyes:	JYes □No					tion □Researd	ch
Case Follow Up Report Case Follow Up In Image Case	Heart Valves:	lYes □No	If not accepted, reason	:				
Recovery Complete Notification: Eyes:/ by: multi-tissue:/ by: with: by: with:	Skin:	JYes □No	If not accepted, reason	:				
Recovery Complete Notification: Eyes:/	Bones:	JYes □No	If not accepted, reason	1:				
Recovery Complete Notification: Eyes:/								
Body Release:/				Case Follow	Up Report			
Body Release:/	Recovery Compl	lete Notificati	ion: Eyes:/_	/ Tir	M	ulti-tissue:		Time
If Coroner Case: Coroner's office notified of recovery completion:	Body Release:	/ /				with:		
Date Time Coordinator Name Confirmed:			Time	Coordina	ator Name		Name Hospita	al Staff / Department
Important issues, learning opportunities and follow-up: Missed Tissue Opportunity Eyes	If Coroner Case:	Coroner's o	office notified of recovery	completion:				rdinator Nama
Missed Tissue Opportunity Eyes	Confirmed: $\square \Delta$	utoney I	No Autoney		Date	Time	C00	rumator Name
Missed Tissue Opportunity Eyes				OW-IID:				or 🗖 N/A
Eyes	important issue	es, learning	opportunities and ion	ow-up.				OI LINA
Eyes								
Eyes								
Eyes								
Eyes								
Eyes								
Eyes								
Eyes								
Eyes								
Eyes	Missod Tissur	o Opportur	nity					
Heart Valves			-					
Skin								
Bones								
If Yes: Family notified ☐ yes via phone or ☐ no after several documented attempts ☐ yes via letter Incident report completed:/ Name:								
Incident report completed:/Name:	Bones		res					
Incident report completed:/Name:	If Yes: Family notified ☐ yes via phone or ☐ no after several documented attempts							
			☐ yes via	a letter				
	Inciden	Incident report completed:/ Name:						
			dd mm					

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