Trillium Gift of Life Network

Trillium Gift of Life Network
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Tel (24/7): 1.888.603.1399 Fax: 1.866.557.6100
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CSF-9-24

NOTICE OF EXCEPTIONAL DISTRIBUTION

SECTION 1: Donor Identification (Please submit one form per recipient)

TGLN Donor #:

SECTION 2: Reason for Exceptional Distribution (ExD)

Health Canada Reason:

☐ Positive Blood Cultures/Active Infections of clinical significance ☐ History of Malignancy ☐ History of dementia/degenerative neuro disease of viral/unknown etiology ☐ Unknown Cause of Death ☐ Unknown on Med/Soc ☐ Unknown Sex History ☐ Risk on Physical Assessment or Incomplete ☐ Risk of CJD or other Prion related disease	☐ Positive Serology ☐ Positive NAT ☐ Diluted Serology sample ☐ Diluted NAT sample ☐ Missing Serology ☐ False positive/repeat reactive/equivocal serology (BC/TQ only) ☐ Missing mandatory organ specific test	Increased Risk for Transmission of Hep B/Hep C/HIV – High Risk Behaviours: ☐ Non-medical injection of drugs in preceding 12 months ☐ Known Sex History Risk ☐ Incarceration > 72h in last 12 months ☐ Tattoo/Piercing with non-sterile procedures < 12 months ☐ Intranasal drug use for non-medical reasons < 6 months ☐ Other:____________________

Other Reason(s) (Health Canada, TGLN and/or Other Source Establishment with source indicated in brackets):

☐ Travel to/Lived in History with risk for: ____________________

☐ Other: ____________________

SECTION 3: Post Release

Only complete if there are outstanding test results/information at time of release that will be available post release

Details of outstanding information or test results: ____________________

Date/Time of Result Received:	____/____/____ (DD / MM / YYYY)	____:____ (HH : MM)	____________ CSC Name:
Date/Time Post-release Results were sent to Transplant Program:	____/____/____ (DD / MM / YYYY)	____:____ (HH : MM)	____________ CSC Name:

SECTION 4: Confirmation of Transmission of Information

Recipient # **(If known)**			
Organ Name	*Please select appropriate organ(s). If other, please specify.* ☐ Heart ☐ Lung ☐ Liver ☐ Pancreas ☐ Kidney(s) ☐ Other:__________		
Transplant Program	*Please select appropriate program. If other, please specify.* ☐ UHN ☐ LHSC ☐ HAM ☐ SMH ☐ HSC ☐ KGH ☐ OHI ☐ OTT ☐ Other: __________		
Reason for ExD Acceptance	*Please select appropriate reason. If other, please specify.* ☐ Benefit Outweighs Risk ☐ Other (Specify): __________		
Date/Time of Acceptance of ExD	**Date:** ____/____/____ (DD / MM / YYYY)	**Time:** ____:____ (HH : MM)	**Name (Role):** ____________

SECTION 5: Confirmation of Organ Acceptance – *To be completed by Transplant Program*

I (or my authorized designate) have had a conversation with the recipient and/or next of kin/substitute decision maker in which I explained the reason(s) for Exceptional Distribution as defined above, and the risks associated with the reason(s). I have obtained informed consent from the recipient and/or next of kin/substitute decision maker and I authorize the acceptance of the organ(s) described above for Transplant.

Authorizing Physician: ____________________

Authorizing Signature: ____________________ **Date:** ____/____/____ (DD / MM / YYYY) **Time:** ____:____ (HH : MM)

To meet requirements of the Health Canada Regulations, please return signed form within **two weeks of receipt** to TGLN: (416)-214-7797 or 1-866-557-6100 (Toll Free) or #OH-TGLN_csc@ontariohealth.ca