PANCREAS FOR ISLETS TRANSPLANT OPERATING ROOM DATA

TRILLIUM GIFT OF LIFE
483 Bay Street South Tower, 4th Floor Toronto, Ontario M5G2C9
Telephone (24/7): 1.877.363.8456 Facsimile: 1.866.557.6100
CTO # 100062

TRANSPLANT PROGRAMS:

TORONTO: RETURN TO ORIGINATING COOLER AND NOTIFY TGLN FOR COOLER PICK UP.
OUTSIDE TORONTO: FAX BOTH SIDES OF FORM TO TGLN @ 1-866-557-6100.

CONTACT TGLN IF YOU HAVE ANY QUESTIONS

DONOR INFORMATION

DONOR TGLN #: ___________ **DONOR CTD #:** __________ RECOVERY SURGEON: ____________________

DONOR AGE: _____ **DONOR** ABO & Rh: _____ **DONOR** HT: ____cm **DONOR** WT: ___ kg **DONOR** CMV (P/N): ________

NDD ☐ **CROSS CLAMP:** DATE: _________________ TIME: ___________ EST

RETRIEVAL TIME: DATE: _________________ TIME: ___________ EST

DCD ☐ **START WIT (WLS):** DATE: _________________ TIME: ___________ EST

FLUSH TIME (END WIT)/CROSS CLAMP: DATE: _________________ TIME: ___________ EST

TOTAL WIT: TIME ____________ **(minutes)**

RETRIEVAL TIME: DATE: ________________ TIME: ___________ EST

Perfusion/Storage Solution Manufacturer: ________________ Lot # _________________ Expiry Date: ____________

DONOR PANCREAS FOR ISLETS DESCRIPTION:

Pancreas for Islets to be stored at temperatures of <0°- 10°

CONFIRMATION OF DELIVERY: ISLET LAB

RECEIVING INSTITUTION: ____

ACCEPTING STAFF: _____________________________ DATE: _________________ TIME: ___________ EST

SIGNATURE: ___________________________________

RECIPIENT INFORMATION

RECIPIENT TGLN #: __________

RECIPIENT CTR #: __________

RECIPIENT HT: _______**cm** **RECIPIENT** WT: ______**kg**

RECIPIENT CMV (P/N**):** ______ **RECIPIENT** ABO & Rh: _____

RECIPIENT PRIMARY DISEASE: ______________________________

TRANSPLANT DATE**:** ____

TRANSPLANT HOSPITAL: ___________________________________

MRN #: __________________

(May use hospital sticker or stamp if available)

June 8, 2017