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TGLN #_____

Tissue Recovery Form

Tissue Team	
Name:	Lead TRC or Recovery TRC

RECOVERY SITE INSPECTION	
Referring Organization:	
Recovery Site:	
Recovery Site Type:	
Recovery Site Details:	

Pre-Recovery Assessment			
Parameters	**Yes**	**No**	**Correction**
Date-Time of inspection:			
1. Adequate floor and tabletop space to allow separation of sterile instrumentation and performance of aseptic recovery procedures (i.e., zone recovery, sequencing, draping, tissue wrapping) is present.			
2. Adequate lighting to perform physical assessment and tissue recovery is present.			
3. Adequate plumbing and drainage for the intended purpose to include access to an adjacent or suitably located hand-washing area that can be used to perform a hand/forearm surgical scrub or wash is present.			
4. The recovery area has a controlled, closed airflow system. There is no direct access to the outside of the building from the room at any time during, before, or after tissue recovery (i.e. door, windows that can open, fans, air conditioners, etc.). In addition, all vents appear clean and there is no vented airflow noted to be directed and flowing onto sterile fields.			
5. The walls, floor, and work surfaces are easily cleanable (i.e., non-carpeted, not porous) and in a good state of repair.			

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

6. Signs of insects, rodents, or other pests are not visible.			
7. Standing fluids or contaminated waste in the room, that could be a source of airborne bacteria, mycobacteria, yeasts or fungi, are not present.			
8. The recovery room was properly prepared by cleaning and disinfecting all working surfaces prior to recovery of tissue.			
Additional Comments: ❒ N/A			

Concurrent With Recovery

Parameters	Yes	No	Correction
Date-Time of inspection:			
9. Human traffic is restricted and all personnel entering the recovery area are properly outfitted and their movement controlled.			
10. Other activities (e.g., embalming, autopsy, another tissue donor recovery) did not occur simultaneously in the same room as this tissue recovery.			
Additional Comments: ❒ N/A			

Post-Recovery Activities

Parameters	Yes	No	Correction
Date-Time of inspection:			
11. All contaminated/biohazardous re-usable supplies were decontaminated, and adequately contained for transport and that contaminated/biohazardous waste was properly disposed, or contained and transported to a disposal site.			
12. All working surfaces and the floor were cleaned using approved solutions and equipment.			
Additional Comments: ❒ N/A			

As signed below, the above parameters have been met and the recovery site has been determined to be suitable.	
TRC Name:	TRC Signature:
Date:	Time:

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Trillium Gift of Life Network

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TGLN #_____

Donor Refrigeration	
❒ Donor Not Cooled	
Type of Refrigeration:	
Information Source:	
Date-Time of Death:	
❒ Asystole ❒ Last Known Alive ❒ Cross Clamp	Date: _____ Time: _____
Refrigeration Date-Time	Elapsed Time
Placed Into:	
Taken Out Of:	
Placed Into:	
Taken Out Of:	
Total Time Cooled:	
Total Time not Cooled	
Comments:	

MEDICAL RECORDS REVIEW	
Record	**Name:**
Current Hospitalization:	
Hospital Record	
ME/Coroner Report	
Physician	
Authorizing Person	
EMS Record	
Nursing Home Record	
Medical/Social Donor History	
Laboratory Reports	

Ontario
Trillium Gift of Life Network

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TGLN #_____

Exporting Eye bank Tissue Information	
TGLN	
Bone Bank	
Other:	

CLINICAL COURSE	
Additional Findings:	
Do records or other information indicate the potential donor was ventilated prior to death?	Y / N
Past Medical/Surgical History:	
Medications (Home):	
Medications (Hospital):	

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Trillium Gift of Life Network

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TGLN #_____

WBC/TEMPERATURES

WBC

❒ No WBCs performed

Date-Time	Count

TEMPERATURE

❒ No Temperatures Recorded

Date-Time	Result (°C/°F)	Cooling Protocol (Y/N)

Comments:

DIAGNOSTIC TESTS

❒ Tests Not Done

Type:	
Date-Time:	
Diagnostic evaluation/results:	
Type:	
Date-Time:	

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

Diagnostic evaluation/results:	
Type:	
Date-Time:	
Diagnostic evaluation/results:	

CULTURES		
❒ No Cultures Done		
Culture Source	**Date-Time**	**Result**

Following a review of the Tissue donor Information Form(s), Authorization Form, Physician Interview Form (if completed), Medical History and Behavioral Risk Assessment Questionnaire and Medical Records as available and appropriate, OPO Tissue Recovery Paperwork, and to the best of my knowledge and in accordance with the accepted standards by the American Association of Tissue Banks, Health Canada Requirements and TGLN, I have determined that this donor is suitable for tissue recovery.

Final acceptance of the donor is the responsibility of the Medical Director at the establishment that releases the tissue as available for distribution. Final determination of acceptance of the donor is the responsibility of the tissue processor.

TRC Signature:	Date-Time

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Trillium Gift of Life Network

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TGLN #_____

PHYSICAL ASSESSMENT

IDENTIFICATION

Name on Consent Form to Donate Organs and Tissues

Last Name: First Name:

Manner identified by:

❒ Toe Tag ❒ Wrist Band ❒ Ankle Band ❒ Body Bag ❒ Shroud Tag ❒ Other

If Other, then must describe how identified and by whom:

IDENTIFICATION BAND/TAG

ID Tag Re-Created:

The body's physical characteristics (e.g. age, gender, race, height, weight, signs associated with the cause of death, or information on the MSHx form) are consistent with available relevant medical records, and the identification is consistent with other documents.
If answered 'No', contact TOC for guidance before proceeding with recovery.

Personnel verifying donor ID:	**Date-Time (Eastern):**

GENERAL APPEARANCE/EVIDENCE OF DONATION

Height (cm): If reported, source:	**Weight (Kilograms):** If reported, source:

Cleanliness: Good / Poor
If poor, Explain:

Evidence of:
Ocular Donation: Yes ❒ No ❒ Organ Donation: Yes ❒ No ❒

Are there signs of any of the following?		Explain "Yes" answers, or any "unable to visualize/palpate" or N/A
Jaundice	Yes ❒ No ❒	
Genital lesions	Yes ❒ No ❒	
Enlarged/Abnormal lymph node(s)	Yes ❒ No ❒	

Ontario
Trillium Gift of Life Network

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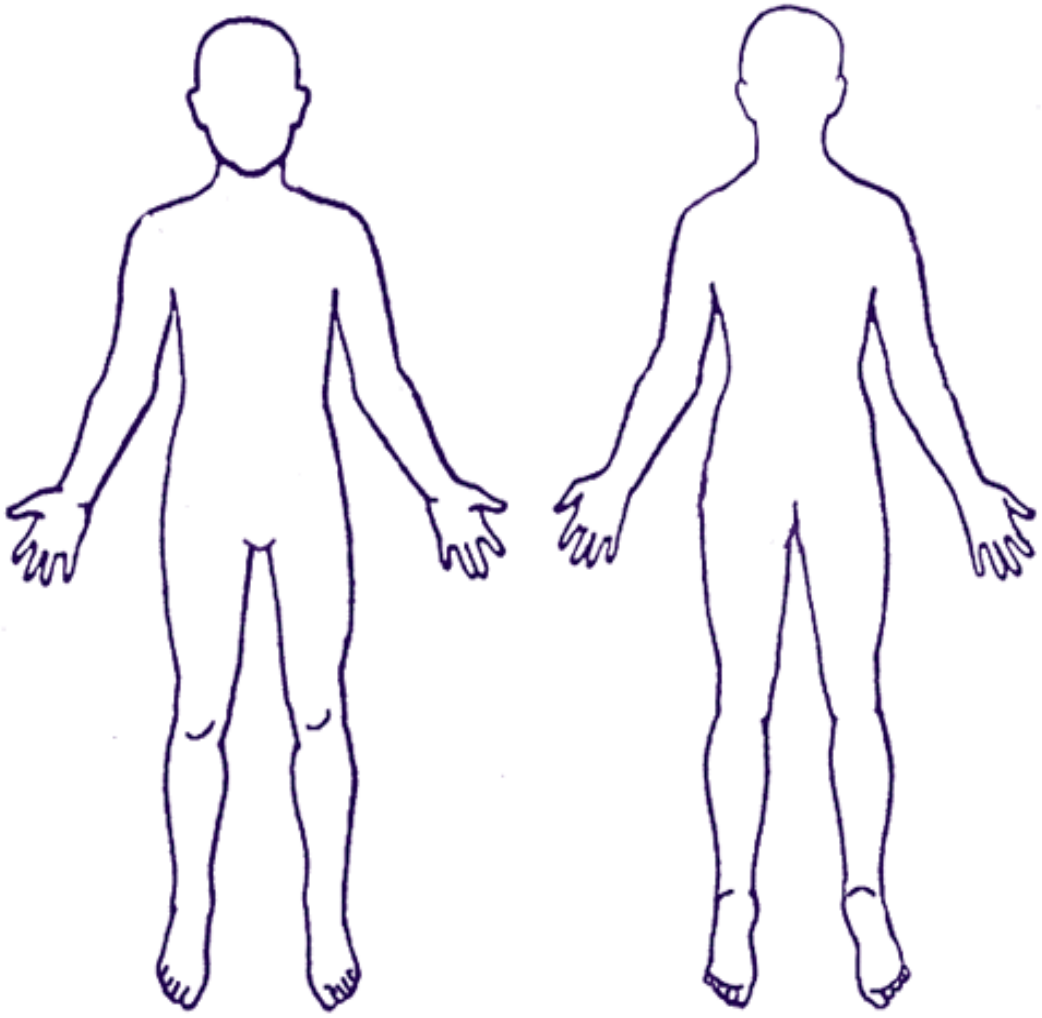
TGLN #_____

White/Yellow spots in the mouth	Yes ❒ No ❒ ❒unable to visualize	
Non-medical injection site	Yes ❒ No ❒	
Enlarged liver	Yes ❒ No ❒ ❒unable to visualize	
Perianal lesions or Anal trauma	Yes ❒ No ❒	
Blue/Purple (gray/black) spots/lesions	Yes ❒ No ❒	
Trauma/infection to tissue recovery areas	Yes ❒ No ❒	
Rash/scab/skin lesion (non-genital)	Yes ❒ No ❒	
Tattoos/piercing	Yes ❒ No ❒	
Abnormal ocular findings (e.g. icterus, scarring)	Yes ❒ No ❒ ❒unable to visualize (eye donor)	
Comments:		

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____



Assessment Key		
1 - ETT	**12 – Peripheral IV**	**22 – Dressing/Bandage**
2 - Trach	**13 – Needle Site: Hospital**	**23 – Cast/Ortho Device**
3 - Chest Tube	**14 - Needle Site: Non-Hospital**	**24 – Body Piercing**
4 – NG/OG/Feeding Tube	**15 – Temperature Probe**	**25 – Tattoo (requires description)**
5 - Foley	**16 – Surgical Scar/Incision**	**26 – Skin Lesion/Rash/Genital Lesion (required description**
6 – Arterial Line	**17 – Other Scars**	**27 – Other**
7 – Central Line	**18 – Laceration/Wound**	**28 - Unremarkable**
8 – PA Cath Line	**19 - Abrasion**	**( ) _____**
9 – Track Marks	**20 – Bruise/Contusion**	**( ) _____**
10 – Other IV Site	**21 – Fracture/Dislocation**	**( ) _____**
11- Drains		**( ) _____**

Ontario
Trillium Gift of Life Network

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TGLN #_____

❒ Check if no observations noted (front) ❒ Check if no observations noted (back)	
Were photos of the body taken? ❒ Yes ❒ No	
Location of Photos:	
Did consultation of physical assessment findings occur? ❒ Yes ❒ No	
Comments:	
Physical Assessment performed by:	
Name:	Date-Time:
Name:	Date-Time:

Personal effects with body: ❒ Yes ❒ No	
If yes, please describe (e.g. Clothing, Wallet/Purse, Jewelry):	
SUMMARY	
A review of available relevant medical records and physical assessment findings were completed prior to recovery and found to be:	
Responsible Person:	Date-Time (Eastern):
Signature:	

Ontario
Trillium Gift of Life Network

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TGLN #_____

TRANSFUSION/INFUSTION- HEMODILUTION WORKSHEET

Was patient transferred from another hospital? ❒No ❒Yes if Yes, Departure Date: ____/____/_____ Time: _____

Did patient arrive via ambulance? ❒No ❒Yes if Yes, Arrival Date: ____/____/_____ Time: _____

Were fluids administered at admission? ❒No ❒Yes

The health care provider was asked for and provided the total volumes of red blood cell containing products and colloids in the 48 hours prior to blood collection/death, and the total crystalloids infused in the 1 hour prior to blood collection/death:

Name HCP: _____ **Date:** _____ **Time:** _____

Blood sample: ❒pre-mortem ❒post-mortem Date and time of collection: ____/____/_____ @ _____hours or ❒not applicable

A Red Blood Cell containing products infused in the 48-hour period prior to the sample evaluation time. Examples include: whole blood, packed red blood cells, and reconstituted blood.		B Colloids infused in the 48-hour period prior to sample evaluation time. Examples include: plasma, albumin, dextran, Pentaspan, platelets, cryoprecipitate and IV Total Parenteral Nutrition (TPN), Parenteral Hyperalimentation (PHA)		C Crystalloids infused in the 1-hour period prior to the sample evaluation time. Examples include saline solutions, lactated ringers etc. *Mannitol & 3% Saline volume X 3	
Product	Volume	Product	Volume	Product	Volume

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

Please note: <u>If the donor weight is greater than 100 kg, use the PV and BV values for 100 kg.</u>

❒ **Method 1: For donors between 45 and 100 kg, use** the chart below to calculate the plasma volume (PV) and blood volume (BV).	❒ **Method 2: For donors less than 45 kg or more than** 100kg, use the equations below to calculate the PV and BV:
Donor Weight (kg) = _____kg	**Donor Weight (pounds ÷ 2.2) = _____kg**
Plasma Volume (PV) = _____ml	PV = Donor weight (kg) _____÷ 0.025 = _____ml
Blood Volume (BV) = _____ml	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

Determination of Suitability

Total from B + C = _____ml Is this greater than the plasma volume? ❒ Yes ❒ No

Total from A + B + C = _____ml Is this greater than the blood volume? ❒ Yes ❒ No

❒ The answer to both questions is 'No', therefore the sample is **acceptable** for testing

❒ The answer one or both questions is 'Yes', the sample is **unacceptable** for testing ⇨ find alternate sample for transplant purposes

Calculation performed by: _____ Date: _____/_____/_____

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

Alternate Sample Available: ❒Yes ❒No Location/Department: _____ Type of Tubes and Amounts: _____
Comments: ❒ N/A

BLOOD COLLECTION INFORMATION				
By	Tube Type	Qty	Draw Date/Time/ Collection Site on Donor	Refrigeration Location: _____
			Date: Time: Site:	Date: Time:
			Date: Time: Site:	Date: Time:
			Date: Time: Site:	Date: Time:
			Date: Time: Site:	Date: Time:
			Date: Time: Site:	Date: Time:

TRC Name:	Signature:
Date:	Time:

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

CASE INITIATION		
Task	**Date**	**Time**
Enter Recovery Room		
Case Start		
Skin Start		
Skin Complete		
PREP		
Skin Prep		
MS Prep		
Cardiac Prep		
INCISION		
MS Tissue Incision		
Cardiac Incision		
Skin Incision		
First Incision		
CULTURES		
First MS Culture		
PLACED IN COLD SOLUTION		
Cardiac Tissue in Cold Rinse Solution		
PLACED ON WET ICE		
Last MS Tissue Placed on Wet Ice		
Last Skin Tissue Placed on Wet Ice		
Last Cardiac Tissue Placed on Wet Ice		
Pericardium Placed on Wet Ice		
Heart for valves Placed on Wet Ice		
Descending Aorta p[laced on Wet Ice		
CASE COMPLETION		
Case Complete		
Post Recovery Room Clean		
Exit Recovery Room		
Departure from Recovery Site		

Ontario
Trillium Gift of Life Network

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TGLN #_____

ZONE 1- SKIN	
❒ No Skin Tissue Procured	
Processor:	
Recovery Site:	
Skin Start Date-Time:	
Skin End Date-Time:	
Donor Prep Solution Used:	
Lubricant Used:	
Preserved In:	
Factors Affecting Quality or Quantity of Skin? ❒ Yes ❒ No If Yes, Explain:	
Deviation from SOP? ❒ Yes ❒ No	
Additional Recovery Comments? ❒ Yes ❒ No	
POSTERIOR TRUNK SKIN	
Recovered?	❒ Yes ❒ No
Recovering Tech:	
Prep Tech:	
Start Date-Time:	
Date-Time placed on Wet Ice:	
POSTERIOR LEGS SKIN	
Recovered?	❒ Yes ❒ No
Recovering Tech:	
Prep Tech:	
Start Date-Time:	
Date-Time placed on Wet Ice:	

Ontario
Trillium Gift of Life Network

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TGLN #_____

ANTERIOR TRUNK SKIN	
Recovered?	❒ Yes ❒ No
Recovering Tech:	
Prep Tech:	
Start Date-Time:	
Date-Time placed on Wet Ice:	
ANTERIOR LEGS SKIN	
Recovered?	❒ Yes ❒ No
Recovering Tech:	
Prep Tech:	
Start Date-Time:	
Date-Time placed on Wet Ice:	

ZONE 2- CARDIAC TISSUE	
❒ No Cardiac Tissue Procured	
Heart Valves	
Recovered?	❒ Yes ❒ No
Processor:	
Recovery Site:	
Recovery Tech:	
Incision Date-Time:	
Estimated Amount of Pericardial Fluid:	
Date-Time Placed on Wet Ice:	
Packaging Solution:	
Rinse Procedure Performed:	❒ Yes ❒ No
Rinsing Solution:	
Apex opened?	❒ Yes ❒ No
Number of Times Heart was Rinsed:	
Evidence of Disease, Trauma or Surgery: ❒ Yes ❒ No If yes, explain:	

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

Deviation from Sop? ❒ Yes ❒ No If yes, explain:
Additional Recovery Commetns: ❒ Yes ❒ No

PERICARDIUM	
Recovered:	❒ Yes ❒ No
Processor:	
Recovery Site:	
Recovery Tech:	
Incision Date-Time:	
Date-Time Placed on Wet Ice:	
Packing Solution:	
Rinse Procedure Performed	❒ Yes ❒ No
Rinsing Solution:	
Number of Time Pericardium was Rinsed:	

Evidence of Disease, Trauma or Surgery: ❒ Yes ❒ No If yes, explain:
Deviatiomns from SOP: ❒ Yes ❒ No If yes, explain:
Additional Recovery Comments: ❒ Yes ❒ No

Ontario
Trillium Gift of Life Network

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TGLN #_____

ZONE 3-MUSCLEOSKELETAL TISSUE	
❒ No Muscleoskeletal Tissue Procured	
Processor:	
Recovery Site:	
Left Side Incision Date-Time:	
Right Side Incision Date-Time:	
Musculoskeletal Tissue Placed on Wet Ice Date-Time:	
Evidence of Disease, Trauma or Surgery: ❒ Yes ❒ No If yes, explain:	
Deviations from SOP? ❒ Yes ❒ No If yes, explain:	
Additional Recovery Commetns: ❒ Yes ❒ No	

ZONE 3 – MUSCLEOSKELETAL TISSUE SEQUENCING					
TRC Left:			**TRC Right:**		
Tissue Detail Zone Sequence	**Recovered (check all that apply)**	**Sequence**	**Tissue Detail Zone Sequence**	**Recovered (check all that apply)**	**Sequence**
Left Humerus			Right Humerus		
Left Radius			Right Radius		
Left Ulna			Right Ulna		
Left Fascia Lata			Right Fascia Lata		
Left Gracilis Tendon			Right Gracilis Tendon		
Left Semitendinosus Tendon			Right Semitendinosus Tendon		

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

Left Anterior Tibialis Tendon			Right Anterior Tibialis Tendon		
Left Posterior Tibialis Tendon			Right Posterior Tibialis Tendon		
Left Peroneus Longus Tendon			Right Peroneus Longus Tendon		
Left Peroneus Brevis Tendon			Right Peroneus Brevis Tendon		
Left Tibia with Patellar Tendon and Meniscus			Right Tibia with Patellar Tendon and Meniscus		
Left Fibula			Right Fibula		
Left Achilles Tendon with Calcaneus and Talus			Right Achilles Tendon with Calcaneus and Talus		
Left Femur			Right Femur		
Left Hemi-Pelvis			Right Hemi-Pelvis		
Left Shoulder En Bloc			Right Shoulder En Bloc		
Left Elbow En bloc			Right Elbow En bloc		
Left Proximal Femur			Right Proximal Femur		
Left Knee En Bloc			Right Knee En Bloc		
Left Ankle En Bloc			Right Ankle En Bloc		
Other:			Other:		
Other:			Other:		
Other:			Other:		
Additional Recovery Comments? ❒ Yes ❒ No Comments:					

I certify the equipment used was sterile and in working order, that the tissue was recovered in the sequence documented above, that the donor was reconstructed per TGLN procedure, and that all applicable TGLN protocols have been followed.

Name: _____ Signature: _____ Date: _____

Ontario
Trillium Gift of Life Network

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TGLN #_____

DEVIATIONS
Deviation form CPI: ❒ Yes ❒ No If Yes, Explain:

ADDITIONAL INFORMATION AND COMMENTS	
Body Reconstruction Complete:	❒ Yes ❒ No
Body Disposition:	
VERIFICATIONS	
Bone and Soft Tissue:	
Labelled by:	
Verified By:	Date-Time:
Verified By:	Date-Time:
Cardiac	
Labelled by:	
Verified By:	Date-Time:
Verified By:	Date-Time:
Skin:	
Labelled by:	
Verified By:	Date-Time:
Verified By:	Date-Time:
Additional Comments: ❒ Yes ❒ No	

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

TRANSPORTATION FOR TISSUE					
Ground					
Trip	Agency	From To	Details	Team	Method
1					
2					
3					

Air						
Flight	Aircraft type	Carrier	Flight #	From To	Details	Team
1						
2						
3						

TISSUE SUPPLY LIST						
Supply	**Manufacturer**	**Lot #**	**Load #**	**Sterilization Indicator Y / N**	**Expiry Date/Manufacturer Date/Sterilization Date**	**# of Units Used**
70% Isopropyl Alcohol						
Alcohol Wipes						
Amalgatome						
Amalgatome Blades						
Amalgatome Power Supply and Power Cord						
Avagard						
Bactec Blood Culture Vial- Aerobic						

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

TISSUE SUPPLY LIST						
Supply	**Manufacturer**	**Lot #**	**Load #**	**Sterilization Indicator Y / N**	**Expiry Date/Manufacturer Date/Sterilization Date**	**# of Units Used**
Bactec Blood Culture Vial- Anaerobic						
Bag Decanter						
Betadine						
Blood Draw Needles						
Blood Draw Syringe						
Blood Tube, EDTA						
Blood Tube, Red Top						
Blood Tube, Tiger Top						
Blood Tube, Yellow top						
Cardiac Drapes						
Chlorohexidine Gluconate						
Chlorohexidine Gluconate Soap (lubricant)						
Culture Swabs						
Dura Prep						
E-Z Scrub Sponges						
EPS Shipper						
Heart Container						
Ioban (large)						
Ioban (small)						

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

TISSUE SUPPLY LIST						
Supply	**Manufacturer**	**Lot #**	**Load #**	**Sterilization Indicator Y / N**	**Expiry Date/Manufacturer Date/Sterilization Date**	**# of Units Used**
Instrument Tray with Basin, Heart Valve						
Instrument Tray, MS						
Isolation Bags						
Lactated Ringers						
Lap Sponges						
Mayo Stand Covers						
Metal Gloves- Small						
Metal Gloves- Medium						
Metal Gloves-Large						
Metal Gloves- X-Large						
Nano Cooler						
Nano Cooler Lid						
OR Towels						
Recovery pack, Skin						
Recovery pack, MS						
Scalpel, Blades						

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

TISSUE SUPPLY LIST						
Supply	**Manufacturer**	**Lot #**	**Load #**	**Sterilization Indicator Y / N**	**Expiry Date/Manufacturer Date/Sterilization Date**	**# of Units Used**
Scalpel, Disposable						
Scrub Stat-4						
Sterile Saline						
Sterile Gloves 6.5						
Sterile Gloves 7.0						
Sterile Gloves 7.5						
Sterile Gloves 8.0						
Sterile Gloves 8.5						
Sterile Gloves 9.0						
Table Drape						
Tis-U-Sol						
Umbilical Tape						

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

Date	Time	Clinical Notes	Initials

Ontario
Trillium Gift of Life Network

All dates should be DD/MM/YY. Time should be in military time and ET unless otherwise specified

TGLN #_____

Date	Time	Clinical Notes	Initials