LIVER / KIDNEY 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

LIVER: ________________ **KIDNEY:** ________________

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

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

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

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

DONOR LIVER / KIDNEY DESCRIPTION:
Vessels Enclosed: Y ☐ **N** ☐
Normothermic Perfusion Pump: Y ☐ **N** ☐
Kidney on Pump: Y ☐ **N** ☐

RECIPIENT INFORMATION

RECIPIENT TGLN #: ____________

RECIPIENT CTR #: ____________

MRN #: __________________

(May use hospital sticker or stamp if available)

RECIPIENT HT: ___________ **cm** **RECIPIENT WT:** ________ **kg**

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

RECIPIENT PRIMARY DISEASE: ________________________________

TRANSPLANT HOSPITAL: ________________________________

RECIPIENT OR: PLEASE COMPLETE THIS BOX

Liver

TRANSPLANT TYPE: FULL GRAFT: ☐ SPLIT/CUTDOWN: ☐

*** TRANSPLANT START:** DATE: ____________________ TIME: _______________ EST

*** PORTAL VIEN CROSS CLAMP:** DATE: ____________________ TIME: _______________ EST

*** REMOVED FROM COLD:** DATE: ____________________ TIME: _______________ EST

*** REMOVED FROM NORMOTHERMIC PERFUSION PUMP:** DATE: ____________________ TIME: _______________ EST

*** PORTAL VIEN CLAMP OFF:** DATE: ____________________ TIME: _______________ EST

*** HEPATIC ARTERY CLAMP OFF:** DATE: ____________________ TIME: _______________ EST

Vessels Used (please identify): **Y** ☐ **N** ☐

RN:
Please fill in these OR times. Thank you

*- **TGLN***

June 8, 2017

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Kidney

TRANSPLANT TYPE: ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

***TRANSPLANT START:** DATE: _______________ TIME: _______________EST

*** REMOVED FROM COLD:** DATE: _______________ TIME: _______________EST

*** CLAMPS OFF:** DATE: _______________ TIME: _______________EST

Vessels Used (please identify): **Y** ☐ **N** ☐

LIVER: _______________ **KIDNEY:**_______________

DONOR TGLN #: _________ **DONOR CTD #:** _______________

CONFIRMATION OF DELIVERY

Exceptional Distribution: Y ☐ N ☐

If Yes, reason: ____

Name of surgeon accepting: ____

Delivered by: ____ (Name – please print)

Date: ______________________________ **Time:** ____________________ **EST**

Receiving Hospital: ____

Accepting Staff: ____________________ (Name – please print) **Signature:** ____________________

OTHER (please specify)**:** ____

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