LUNG 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

☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

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

CARDIAC ARREST TIME: DATE: _______________ TIME: ___________ EST

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

TOTAL WIT (TIME FROM WLS TO FLUSH): TIME: ___________ **(minutes)**

EVLP ☐ **START:** DATE: _______________ TIME: ___________ EST

END: DATE: _______________ TIME: ___________ EST

DONOR LUNG(S) DESCRIPTION:

RECIPIENT INFORMATION

RECIPIENT TGLN #: ____________

RECIPIENT CTR #: ____________

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

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

RECIPIENT PRIMARY DISEASE: ________________________________

TRANSPLANT HOSPITAL: ______________________________________

MRN #: __________________

(May use hospital sticker or stamp if available)

RECIPIENT OR: PLEASE COMPLETE THIS BOX

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

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

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

R: DATE: ____________________ TIME: _______________ EST

*** CLAMP REMOVAL** **L:** DATE: ____________________ TIME: _______________ EST

R: DATE: ____________________ TIME: _______________ EST

RN:
Please fill in these OR times. Thank you

*- **TGLN***

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

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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