

## LIVER / BOWEL 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

OUTSIDE TORONTO. FAX BOTT SIDES OF F	ONW TO TOLIN @ 1-000-33		LN IF YOU HAVE AN	Y QUESTIONS
DONOR INFORMATION		LIVE	R:	
DONOR TGLN #: DONOR O	<b>OR CTD</b> #: RECOVERY SURGEON:			
DONOR AGE: DONOR ABO & Rh:	DONOR HT: cr	m <b>DONOR</b> WT:kg	DONOR CMV (P/N	1):
NDD CROSS CLAMP:	DATE:	TIME:	ES	ST:
DCD START WIT (WLS): FLUSH TIME (END WIT)/CROSS TOTAL WIT:	CLAMP TIME: DATE:	TIME: TIME: (minutes)		
DONOR LIVER / BOWEL DESCRIPTION: Vessels Enclosed: Y N				
RECIPIENT INFORMATION				
RECIPIENT TGLN #:		MRN #:		
RECIPIENT HT: cm R	ECIPIENT WT: k	3		
RECIPIENT CMV (P/N): R	ECIPIENT ABO & Rh:	(May use hospital stick	er or stamp if available)	
RECIPIENT PRIMARY DISEASE:				
TRANSPLANT HOSPITAL:				
RECIPIENT OR: PLEASE COMPLETE T	HIS BOX			RN:
* TRANSPLANT START: D	ATE:	TIME:	EST	Please fill in these
* PORTAL VIEN CROSS CLAMP: D	ATE:	TIME:	EST	OR times. Thank
* REMOVED FROM COLD:	ATE:	TIME:	EST	you
* PORTAL VIEN CLAMP OFF: D	ATE:	TIME:	EST	- TGLN
* HEPATIC ARTERY CLAMP OFF: D	ATE:	TIME:	EST	
Vessels Used (please identify): Y N	1 🗆			



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CONTACT TGLN IF YOU HAVE ANY QUESTIONS

DONOR TGLN #:	DONOR CTD #:	LIVER:	
CONFIRMATIO	N OF DELIVERY		
Exceptional Distribution:	Y  N		
Name of surgeon acceptin	g:		
Delivered by:			(Name – please print)
Date:		Time:	EST
Receiving Hospital:			
Accepting Staff:	(Name – pleas	se print) Signature:	
OTHER (please specify):			