Trillium Gift of Life Network

PANCREAS 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:

DCD ☐ **START WIT (WLS):** DATE: _____ TIME: _____ EST
FLUSH TIME (END WIT)/CROSS CLAMP: DATE: _____ TIME: _____ EST
TOTAL WIT: TIME: _____ **(minutes)**

DONOR PANCREAS DESCRIPTION:
Vessels Enclosed: Y ☐ **N** ☐

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 START:** DATE: _____ TIME: _____ EST
* **REMOVED FROM COLD:** DATE: _____ TIME: _____ EST
*** CLAMPS 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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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): _____

_____

_____

_____

June 8, 2017