COMPOSITE TISSUE TRANSPLANT OPERATING ROOM DATA

Ontario Health
Trillium Gift of Life Network

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

Limb: L/R _____

DONOR TGLN #: _____ **DONOR CTD #**: _____RECOVERY SURGEON: _____

DONOR AGE: ____ **DONOR** ABO & Rh: ____ **DONOR** HT: ____ cm **DONOR** WT: ____kg **DONOR** CMV (P/N): ____

NDD	**TURNIQUET ON:**	DATE: _____	TIME:_____ EST
	TURNIQUET OFF:	DATE: _____	TIME:_____ EST
	CLAMP:	DATE: _____	TIME:_____ EST
	IMMERSION:	DATE: _____	TIME:_____ EST

DONOR COMPOSITE TISSUE 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 SURGEON: _____

TRANSPLANT START:	DATE: _____	TIME: _____EST
* **TURNIQUET ON:**	DATE: _____	TIME: _____EST
* **TURNIQUET OFF:**	DATE: _____	TIME: _____EST
* **REMOVED FROM COLD:**	DATE: _____	TIME: _____EST
* **REVASCULARIZATION:**	DATE: _____	TIME: _____EST

RN:
Please fill in these OR times. Thank you

*- **TGLN***

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DONOR TGLN #: _____ **DONOR CTD #:** _____ **Limb: L/R**_____

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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