Trillium Gift of Life Network
483 Bay Street South Tower, 4th Floor Toronto, Ontario M5G 2C9
Telephone: (24/7) 1 877 363 8456 Facsimile: 1 866 557 6100
Website: www.giftof life.on.ca

Eye Recovery Form

Part A Chart Review

(1) Donor Information

TGLN # ______________________________ Donor Name ____
Last Name, First Name

MRN # _______________________________

(2) Hospital Information

Hospital Name	Hospital Address

(3) Consent Information

Consent: ❒Eyes ❒Corneas ❒Heart ❒Skin ❒Bone and Connective Tissue
❒Research ❒Medical Education ❒ Transplant

(4) Coroner Information

Coroner's Case ❒Yes ❒No If "yes" coroner consent given: ❒Yes ❒No Coroner:____________________________________

Tissue required by Coroner ❒ None ❒ Vitreous ❒ Blood ❒ CV Residual ❒Other ____________________________________

Restrictions/comments ____

(5) Cause of Death

Asystole (cross clamp/LTKA) ____/_____/____ @ ___:____ EST hours Attending and/or Pronouncing Physician_______________
dd mm yyyy hh:mm

Immediate Cause (a)____
of death, giving due to (or as a consequence of)

Antecedent cause(s), (b)____
if any, next due to (or as a consequence of)

(6) Ocular Technician Recovery Timelines

Date-Time Notified:	_______ / _______ / ________ @ ______:______ EST hours dd mm yyyy hh:mm
Date-Time of Departure to Recovery Site:	_______ / _______ / ________ @ ______:______ EST hours dd mm yyyy hh:mm
Date-Time of Arrival at Recovery Site:	_______ / _______ / ________ @ ______:______ EST hours dd mm yyyy hh:mm
Date-Time of Departure from Recovery Site:	_______ / _______ / ________ @ ______:______ EST hours dd mm yyyy hh:mm
Comments: (List any problems, unusual circumstances, instructions received or positive experiences) ❒ N/A	

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(7) Eye Supply List

	Supply	Manufacturer	Lot #	Load #	Sterilization Indicator	Date/Date Type (dd / mm / yyyy)	# of Units
❒	In Situ Kits, Single Use	Stephens Instruments		N/A	❒ Acceptable ❒ Unacceptable ❒ ________	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Eye Jar	Eye Bank of Canada			N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Optisol (OS)	Bausch and Lomb		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Optisol (OD)	Bausch and Lomb		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Corneal viewing chambers	Bausch and Lomb		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Scalpel Blades	Surgeon		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Blood Tube, EDTA	Becton Dickinson		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Blood Tube, Red Top	Becton Dickinson		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Enucleation Kits, Single Use	❒ Krolman Corporation ❒ Stephens Instruments		N/A	❒ Acceptable ❒ Unacceptable ❒ ________	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Prep Swabstick - PVP	PDI Pharmaceuticals Inc.		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Betadine 5%, 3 mL dropper	Krolman Corporation		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	0.9% Sterile Saline, 30 mL vial	❒ Kimberly-Clark Health Care ❒ Winchester Laboratories		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Scrub Brush	Becton Dickinson		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Sterile Drapes	Cardinal Health Canada		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Sterile Gauze	AMD-Ritmed INC.		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Sterile Glove	Medline		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Sterile Sleeve	Cardinal Health Canada		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Syringe	Becton Dickinson		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Needle	Becton Dickinson		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Cotton Tip Applicator	Medline		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Sterile Cotton (EBC)	Cardinal Health Canada	N/A		❒ Acceptable ❒ Unacceptable ❒ ________	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Eye Jar (pink top)	Starplex Scientific Inc		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	
❒	Zip Tie	ULINE		N/A	N/A	________ / ________ / __________ ❒Expiration ❒Sterilization ❒Production ❒Manufacture ❒Date of Use ❒Release	

TGLN # :________________________

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(8) Medical Record Review

History obtained from: ❒Hospital ❒ME/Coroner Report ❒Physician ❒EMS Record ❒Other: __________________

Medical Record Review performed by: ______________________________ Date-Time: _____ / _____ / ____ @ ____:___ EST hours
dd mm yyyy hh:mm

Clinical Course
Additional Findings:
Do records or other information indicate the potential donor was ventilated prior to death? ❒ Yes ❒ No
Past Medical/Surgical History:
Medications (Home):
Medications (Hospital):

TGLN # :________________________

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(9) Current Medical Information

Blood Work ***(if different or additional)***			**Temperature** ***(if different or additional)***		
❒ No WBCs Performed			❒ No Temperatures Performed Reason not recorded: ❒ Within Normal Limits ❒ No Data Available		
Date	Time	WBC	Date	Time	ºC

Diagnostic Tests

❒ Tests Not Done

Type	Date	Time	Diagnostic Evaluation/Results:

Cultures

❒ No Cultures Done

Type	Date	Time	Results

Donor Refrigeration

Elapsed Time Calculator

N/A	Refrigeration Type	Action Taken	Date – Time (dd / mm / yyyy @ hh:mm)	Elapsed Time (hh:mm)	Type	Reason	Information Source
❒	❒ Refrigeration ❒ Ice ❒ _______________	Placed Into Taken Out of	____ / _____ / _____ @ ___:___EST hours ____ / _____ / _____ @ ___:___ EST hours	_____ : ____ _____ : ____	NOT Cooled Cooled	______________ ______________	______________ ______________
N/A	Refrigeration Type	Action Taken	Date – Time (dd / mm / yyyy @ hh:mm)	Elapsed Time (hh:mm)	Type	Reason	Information Source
❒	❒ Refrigeration ❒ Ice ❒ _______________	Placed Into Taken Out of	____ / ____ / _____ @ ___:____ EST hours ____ / ____ / _____ @ ___:____ EST hours	_____ : ____ _____ : ____	NOT Cooled Cooled	______________ ______________	______________ ______________
N/A	Refrigeration Type	Action Taken	Date – Time (dd / mm / yyyy @ hh:mm)	Elapsed Time (hh:mm)	Type	Reason	Information Source
❒	❒ Refrigeration ❒ Ice ❒ _______________	Placed Into Taken Out of	____ / ____ / _____ @ ____:___ EST hours ____ / ____ / _____ @ ____:___ EST hours	_____ : ____ _____ : ____	Not Cooled Cooled	______________ ______________	______________ ______________
			Total Time NOT Cooled: (hh:mm) Total Time Cooled: (hh:mm)	_______ : _______ _______ : _______			

Completed By: ____

TGLN # :________________________

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(10) Hemodilution Calculation Verification

Was patient transferred from another hospital? ❒No ❒Yes if Yes, Departure Date: _______ / _______ / _______ @ ______ : ______ EST hours
dd mm yyyy hh:mm

Did patient arrive via ambulance? ❒No ❒Yes if Yes, Arrival Date: _______ / _______ / _______ @ ______ : ______ EST hours
dd mm yyyy hh:mm

Were fluids administered at admission? ❒No ❒Yes

The health care provider was asked for and provided the total volumes of red blood cell containing products and colloids in the 48 hours prior to blood collection/death, and the total crystalloids infused in the 1 hour prior to blood collection/death:

Name HCP: ____ **Date:** ______ / _______ / ________ **Time:** _______ : _______ EST hours
dd mm yyyy hh:mm

Blood sample: ❒pre-mortem ❒post-mortem Date and time of collection: ______ / ______ / ________ @ ______ : ______ EST hours or ❒N/A
dd mm yyyy hh:mm

A Red Blood Cell containing products infused in the 48-hour period prior to the sample evaluation time. Examples include: whole blood, packed red blood cells, and reconstituted blood.		B Colloids infused in the 48-hour period prior to sample evaluation time. Examples include: plasma, albumin, dextran, Pentaspan, platelets, cryoprecipitate and IV Total Parenteral Nutrition (TPN), Parenteral Hyperalimentation (PHA)		C Crystalloids infused in the 1-hour period prior to the sample evaluation time. Examples include saline solutions, lactated ringers etc. *Mannitol & 3% Saline volume X 3	
Product	Volume	Product	Volume	Product	Volume

Please note: ***<u>If the donor weight is greater than 100 kg, use the PV and BV values for 100 kg.</u>***

❒ **Method 1: For donors between 45 and 100 kg**, use the chart below to calculate the plasma volume (PV) and blood volume (BV).

Donor Weight (kg) = _________________**kg**

Plasma Volume (PV) = _________________mL

Blood Volume (BV) = _________________mL

❒ **Method 2: For donors less than 45 kg or more than 100 kg**, use the equations below to calculate the PV and BV:

Donor Weight (pounds ÷ 2.2) = __________**kg**

PV = Donor weight (kg) ______÷ 0.025 = __________mL

BV = Donor weight (kg) ______÷ 0.015 = __________mL

Calculation Table (round all weights down)

kg	PV	BV	kg	PV	BV	kg	PV	BV	kg	PV	BV
45	1800	3000	59	2360	3933	73	2920	4867	87	3480	5800
46	1840	3067	60	2400	4000	74	2960	4933	88	3520	5867
47	1880	3133	61	2440	4067	75	3000	5000	89	3560	5933
48	1920	3200	62	2480	4133	76	3040	5067	90	3600	6000
49	1960	3267	63	2520	4200	77	3080	5133	91	3640	6067
50	2000	3333	64	2560	4267	78	3120	5200	92	3680	6133
51	2040	3400	65	2600	4333	79	3160	5267	93	3720	6200
52	2080	3467	66	2640	4400	80	3200	5333	94	3760	6267
53	2120	3533	67	2680	4467	81	3240	5400	95	3800	6333
54	2160	3600	68	2720	4533	82	3280	5467	96	3840	6400
55	2200	3667	69	2760	4600	83	3320	5533	97	3880	6467
56	2240	3733	70	2800	4667	84	3360	5600	98	3920	6533
57	2280	3800	71	2840	4733	85	3400	5667	99	3960	6600
58	2320	3867	72	2880	4800	86	3440	5733	100	4000	6667

Determination of Suitability

Total from B + C = _________________mL Is this greater than the plasma volume? ❒ Yes ❒ No

Total from A + B + C = ______________mL Is this greater than the blood volume? ❒ Yes ❒ No

❒ The answer to both questions is 'No', therefore the sample is **acceptable** for testing

❒ The answer one or both questions is 'Yes', the sample is **unacceptable** for testing ⇨ find alternate sample for transplant purposes

If sample is unacceptable for testing, complete the following fields:

Is Alternate Sample Available: ❒Yes ❒No If yes, Location/Department: ____

Type of Tubes and Amounts: ____

Calculation performed by: ____ Date: ________ / _________ / ___________
dd mm yyyy

Comments: ❒ N/A

TGLN # :_________________________

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Part B – Tissue Recovery

(11) Recovery Site Inspection

Recovery Site Type: ______________________ If Other, specify: ________________ Recovery Site Details: ____________________

Pre-Recovery Evaluation			
Date/Time of Inspection (dd / mm / yyyy @ hh:mm): ________ / ________ / __________ @ ______:______EST hours			
Parameter	**YES**	**NO**	**Correction**
1. Adequate floor and tabletop space	❐	❐	
2. Adequate lighting	❐	❐	
3. Adequate plumbing and drainage	❐	❐	
4. The recovery staff has a controlled, closed airflow system	❐	❐	
5. The walls, floor, and work surfaces are easily cleanable	❐	❐	
6. Signs of insects, rodents, or other pests are not visible	❐	❐	
7. Standing fluids or contaminated waste are not present	❐	❐	
8. Work surfaces of recovery room were properly cleaned and prepared prior to recovery	❐	❐	
Additional Comments: ❐ N/A			

Concurrent with Recovery			
Date/Time of Inspection (dd / mm / yyyy @ hh:mm): ________ / ________ / __________ @ ______:______EST hours			
Parameter	**YES**	**NO**	**Correction**
1. Human traffic is restricted, personnel are properly outfitted; movement is controlled	❐	❐	
2. Other activities did not occur simultaneously in the same room as this tissue recovery.	❐	❐	
Additional Comments: ❐ N/A			

Post-Recovery Activities			
Date/Time of Inspection (dd / mm / yyyy @ hh:mm): ________ / ________ / __________ @ ______:______EST hours			
Parameter	**YES**	**NO**	**Correction**
3. All contaminated/biohazardous reusable supplies were decontaminated, and adequately contained for transport; and contaminated/biohazardous waste was properly disposed, or contained and transported to a disposal site.	❐	❐	
4. All working surfaces and the floor were cleaned using approved solutions and equipment.	❐	❐	
Additional Comments: ❐ N/A			

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(12) Physical Examination

Method body identified by: ❒ Toe Tag ❒ Wrist Band ❒ Ankle Band ❒ Body Bag ❒ Shroud Tag ❒ Other
If Other, then must describe how identified and by whom: ________________________________

Technician(s) identifying body: ___________________________________ Technician(s) performing assessment: ___________________________________
First Name and Last Name First Name and Last Name

R L L R

Personal belongings with body? ❒ Yes ❒ No
If yes, please describe: ______________________________

If post-autopsy recovery, did extent of autopsy violate any tissues to be recovered? ❒ Yes ❒ No ❒ N/A

Cornea: ❒ Yes ❒ No | Globes: ❒ Yes ❒ No

Photos taken excluding ID photo? ❒ Yes ❒ No

1 – Abrasion	17 – Rash
2 – Autopsy Incision	18 – Scab
3 – Body Piercing – requires description	19 – Skin lesion
4 – Bruise / Contusion	20 – Scar – Surgical
5 – Cast / Ortho device	21 – Sutures / Staples (surgical)
6 – Dressing / Bandage	22 – Tattoo – requires description
7 – ET Tube / NG tube	23 – Team blood draw site
8 – Fracture / Dislocation	24 – Urethral catheter
9 – Hematoma	25 – Moles / Skin Tags
10 – ID band / tag	26 – Stretch Marks
11 – IV / Arterial line / IO	27 – Unremarkable
12 – Laceration / Wound	A – ____________
13 – Lividity	B – ____________
14 – Needle Puncture Site	C – ____________
15 – Scar – Non-surgical	D – ____________
16 – Organ recovery incision	

Comments:

General Appearance:

Basic Hygiene: ❒ Good ❒ Poor Describe if "poor": ______________________________________ Body profile: ❒ Average ❒ Overweight ❒ Underweight

Physical Assessment

Is there evidence of:		Group Contacted:	Specify Action Taken:
Jaundice / Icterus?	❒ Yes ❒ No		
Genital lesions?	❒ Yes ❒ No		
Enlarged lymph nodes?	❒ Yes ❒ No		
White spots in mouth?	❒ Yes ❒ No ❒ Unable to visualize: __________________		
Non-medical injection sites?	❒ Yes ❒ No		
Infectious precautions known?	❒ Yes ❒ No		
Enlarged liver (hypomegaly?)	❒ Yes ❒ No ❒ Unable to visualize: __________________		
Insertion trauma / perianal lesions?	❒ Yes ❒ No		
Blue/purple or gray/black spots/lesions?	❒ Yes ❒ No		
Trauma to potential retrieval sites?	❒ Yes ❒ No		
Infection to potential retrieval sites?	❒ Yes ❒ No		
Blood loss?	❒ Yes ❒ No		
Rash/scab/skin lesions? (non-genital)	❒ Yes ❒ No		
Tattoos or piercings?	❒ Yes ❒ No		
Abnormal ocular findings?	❒ Yes ❒ No ❒ Unable to visualize: __________________		
Smallpox vaccination or scab?	❒ Yes ❒ No		
Sexually transmitted diseases?	❒ Yes ❒ No		

Explain if any answers are "Yes":

Did consultation of physical assessment findings occur? ☐Yes ☐No

Comments:

Summary:

A review of available medical records and physical assessment findings were completed and found to be: ❒ Acceptable ❒ Not Acceptable

TGLN # :______________________

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(13) Tissue Medical Consult

ID #: TGLN-408836 **Nat'l ID #** --------- **TGLN**
ABO: **O** **Eye ID #:** --------- 483 Bay St, South Tower, 4th floor Toronto Ontario M5G 2C9 CA

TISSUE MEDICAL CONSULT DETAILS

Tissue Type: ---------
Call Made By: ---------

CALL DETAILS

Physician/Consultant Name: ---------
Reason For Call: ☐ Chart Review Findings ☐ Physical Assessment Findings
Date-Time of Call: --/--/---- --:-- **Date-Time of Call Back:** --/--/---- --:--
Outcome: ---------
Defer reason:

Comments:
----

(14) Pen Light Exam

OD OS

1 – Arcus (Note Severity)
2 – Bloodshot
3 – Conjunctiva Edema
4 – Contact Lens
5 – Exposure (Note Severity)
6 – Iridectomy
7 – Opacity / Corneal Scar
8 – Periorbital Swelling
9 – Petechiae
10 – Pterygium
11 – Sloughing (Note Severity)
12 – Subconjunctival Hemorrhage
13 – ______________
14 – ______________
15 – ______________

Comments:

The Physical Assessment was performed prior to: ☐ Ocular Recovery ☐ Tissue Recovery

Ocular Penlight Exam

OD	OS
Condition of Superior Lid: ☐ Unremarkable ☐ Inflammation ☐ Laceration ☐ Edematous ☐ Contusion ☐ Abrasion Comments:	Condition of Superior Lid: ☐ Unremarkable ☐ Inflammation ☐ Laceration ☐ Edematous ☐ Contusion ☐ Abrasion Comments:
Condition of Inferior Lid: ☐ Unremarkable ☐ Inflammation ☐ Laceration ☐ Edematous ☐ Contusion ☐ Abrasion Comments:	Condition of Inferior Lid: ☐ Unremarkable ☐ Inflammation ☐ Laceration ☐ Edematous ☐ Contusion ☐ Abrasion Comments:
Condition of Conjunctiva: ☐ Unremarkable ☐ Discharge ☐ Petechia ☐ Inflammation ☐ Icteric ☐ Pterygium ☐ Bloodshot ☐ Edematous Comments:	Condition of Conjunctiva: ☐ Unremarkable ☐ Discharge ☐ Petechia ☐ Inflammation ☐ Icteric ☐ Pterygium ☐ Bloodshot ☐ Edematous Comments:
Condition of Corneal Epithelium: ☐ Unremarkable ☐ Exposure ☐ Sloughing ☐ Cloudiness ☐ Contact Lens ☐ Glass/Debris Comments:	Condition of Corneal Epithelium: ☐ Unremarkable ☐ Exposure ☐ Sloughing ☐ Cloudiness ☐ Contact Lens ☐ Glass/Debris Comments:

TGLN # :_________________________

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Condition of Corneal Stroma: ❒ Unremarkable ❒ Arcus ❒ Infiltrate ❒ Surgical Scar Comments:	Condition of Corneal Stroma: ❒ Unremarkable ❒ Arcus ❒ Infiltrate ❒ Surgical Scar Comments:
Condition of Intraocular (complete only for in situ recovery): ❒ Phakic ❒ Pseudophakic ❒ Aphakic Comments:	Condition of Intraocular (complete only for in situ recovery): ❒ Phakic ❒ Pseudophakic ❒ Aphakic Comments:
Iris Colour: ❒ Brown ❒ Blue ❒ Green ❒ Hazel ❒ Black ❒ Gray Pupil Diameter (mm): ________ Abnormalities: ________________________________ Evidence of Surgery: ❒ Yes ❒ No If Yes, Specify: ________________________________ Exam Performed By: ________________________	Iris Colour: ❒ Brown ❒ Blue ❒ Green ❒ Hazel ❒ Black ❒ Gray Pupil Diameter (mm): ________ Abnormalities: ________________________________ Evidence of Surgery: ❒ Yes ❒ No If Yes, Specify: ________________________________ Exam Performed By: ________________________

Summary:

A review of available medical records and physical assessment findings were completed and found to be

❒ Acceptable ❒ Not acceptable for recovery by: ________________ on ________ (dd) /________ (mm) / ________ (yyyy) @ ________:________ (hh:mm) EST hours

(15) Blood Draw / Serologies

Blood Draw: Date ________ (dd) /_______ (mm) /________ (yyyy) @ ________:_______ (hh:mm) EST hours ☐ Pre-mortem ☐ Post-mortem

Eye Recovered: Date ________ (dd) /_______ (mm) /________ (yyyy) @ ________:_______ (hh:mm) EST hours

❒ Whole Eye ❒ Cornea Indicate if: ❒ Both Eyes ❒ Left Eye ❒ Right Eye

Site: ❒ Morgue ❒ Unit/Patient/Room ❒ Other ____

Eye recovery procedures were performed according to TGLN CPI's and all instruments/supplies used were sterile. If any incidents or deviations occur please describe in section 10.

16) Tissue Medical Consult

ID #: TGLN-408836 **Nat'l ID #** ---------
ABO: **O** **Eye ID #:** ---------

TGLN
483 Bay St, South Tower, 4th floor
Toronto Ontario M5G 2C9 CA

TISSUE MEDICAL CONSULT DETAILS

Tissue Type: ---------
Call Made By: ---------

CALL DETAILS

Physician/Consultant Name: ---------
Reason For Call: ☐ Chart Review Findings ☐ Physical Assessment Findings
Date-Time of Call: --/--/---- --:-- **Date-Time of Call Back:** --/--/---- --:--
Outcome: ---------
Defer reason:

Comments:

TGLN # :________________________

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(17) Eye Recovery Procedure: Deviations /

Were there any deviations from TGLN or tissue processor policies and procedure during the case? ❒ Yes ❒ No
If yes, please specify

(18) Donor Reconstruction and Disposition

Was the Donor reconstructed according to TGLN CPI's? ❒ Yes ❒ No If "No" Explain: ___________________________________

____

Date ______/______/_______ @ _____:_____EST hours TRC Signature:____
dd mm yyyy hh:mm

Donor disposition/location: ❒ Hospital Morgue ❒ Other

If "Other", please specify: _______________________________ Date and Time _____/_____/______ @ ____:____EST hours
dd mm yyyy hh:mm

(19) Additional Information/Comments

Date	Time	Notes	Initials

TRC(s): ____ **Initials:**_______________________________

Date and Time: _______ **/** _______ **/** ________ **@** ______**:**______ EST hours
dd mm yyyy hh:mm