TRILLIUM GIFT OF LIFE NETWORK - Triage Form

TGLN ID #: ______ Date: / / Time: ______ CSC: ______

Hosp/Unit: Ref'd by: Ph #: Fax #:

Name: ______ **Age:** ______ **Gender:** **M / F** **D.O.B** ______

MRN: ______ OHIP # ______ **(DD / MMM / YYYY)**

MRP (Most Responsible Physician) : Aware of Referral Y / N / U

24/7 Lookup: NA / Y Blank No Info Transplant R&T Exceptions Y / N 24/7 Lookup Given to OTDC: Y / N

Admission History: Date/Time Admitted: ______ Date/Time Intubated: ______

Arrests: Y / N Down Time: Resuscitation: Date/Time of Arrest:

Cooling Protocol: Y / N Discontinuation Date: Time:

Past Medical History: ______

Surgeries: Y / N If Y, Describe (include year):

Cancer: Y / N ______ Date of Diagnosis: ______

Treatment (circle): chemotherapy / radiation / surgery Date(s) of Treatment:

Admission Dx: **Neuro Injury?** Y / N / U **Mechanism of Neuro Injury:**

Cough	Y / N / U	Breathes Above Vent?	Y / N / U	Vent Settings: Mode: RR: Vol: PEEP: FiO2:
Gag	Y / N / U	Sedation	Y / N / U	Meds/Dose/Time: ______
Corneal	Y / N / U	WLS Discussion	Y / N / U	If Y, set time: ______
Withdraws to pain	Y / N / U	Limiting Therapy	Y / N / U	
Pupils	Y / N / U	DNR	Y / N / U	*** paediatric referrals on Bipap may be eligible to donate**

Family Aware of Prognosis Y / N / U Consent: Y / N / U

NOK on site Y / N / U Request for OTDC to come on site Y / N Request made by Family / Staff (Circle)

OTDC Contacted: Y / N Who: Date/Time:

Preliminary Medical Suitability

Suitability Concerns Y / N / U (if yes, describe)

CMO Consulted Y / N Who: ______ Date/Time: ______

Outcome: **CMO Contacted by RTC / OTDC / CSC**

Assessment of Timely Referral

Mention of donation: **Y / N** HCP/MD/Family Time Set for WLS **Y / N** Appears Declarable **Y / N** Poor BP Management **Y / N**

Current Hospital's Plan ______

Follow-Up Plan/Key Messages to Referral Hospital (by RTC / OTDC / CSC)

Call PRC if: Mgmt Concerns ☐ **Approaching NDD** ☐ **Family/HCP Needs Support** ☐ **Planned WLS/Limiting Therapy** ☐

TISSUE CONTRAINDICATORS

HIV/Aids	**Y / N**	Hep C	**Y / N**	Active TB	**Y / N**	Alzheimers	**Y / N**	MS	**Y / N**
Hep B	**Y / N**	CJD	**Y / N**	Isolation Precautions	**Y / N**	Parkinsons	**Y / N**	Leukemia	**Y / N**
MRSA/VRE/ESBL	**Y / N**	Rabies	**Y / N**	C. difficile	**Y / N**	ALS	**Y / N**	Lymphoma	**Y / N**

Chart Transferred to Tissue Desk ☐ **Report Given to:** **Date:** **Time:**

RN Informed to call at T.O.D. **Y / N** Name of HCP

Initial/Signature:

Vital Signs								
Date:								
Time:								
B/P								
MAP								
HR								
CVP/PCWP								
TEMP								
U/O								
IV (SOL'N/RATE)								
BLOOD PROD								
OTHER IV								
BOLUS								

Medications								
Date:								
Time:								
Dopamine								
Levophed								
Vasopressin								
Epinephrine								
Insulin								
T4								
Solumedrol								
DDAVP								
ELECTROLYTE REPLACEMENT								
ANTIBIOTICS								
OTHER								
OTHER								

Labs														
Date:					**Date:**					**Date:**				
Time:					**Time:**					**Time:**				
Na					Bili (T / D)					WBC				
K					AST					Platelets				
Cl					ALT					Hemoglobin				
Bicarb					ALP					Hematocrit				
Urea					LDH					PT				
Cr					Tot. Protein					PTT				
GFR					Albumin					INR				
Glu					Amylase					**ABG's**				
Ca					Lipase					pH				
Mg					GGT					pCO2				
Phos					**ABO**					HCO3				
Lactate					**Height**					pO2				
CK					**Weight**					FiO2				
Trop (T / I)					**TLC**					PEEP				
Urinalysis:	pH		Spec. Gravity			Gluc		Protein		Ketones	Blood		WBC	

Cultures: Y / N If Yes, Source:	**Chest Xray: Y / N** If Yes, Result:
Result:	
Abx:	

Clinical Notes			
Date	**Time**	**Notes**	**Initials**
Initial/Signature:			

Clinical Notes			
Date	**Time**	**Notes**	**Initials**
Initial/Signature:			

Follow up on Open Referral

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time:

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time:

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time:

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time:

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time:

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time:

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time:

by CSC/OTDC: **Date:** **Time:** **Name of HCP:**

Hospital Care Plan Change **Y / N** V/S Stable **Y / N** On Inotropes **Y / N**

On site support/chart review required **Y / N**

Plan to Limit Therapy **Y / N** Family Bring Up WLS - Stopping tx **Y / N** Key Messages to HCP **Y / N**

Next Follow up by CSC/OTDC in hrs. Date: Time: