

Northern Strategy Package

Dear _____

Thank you for your time and assistance in supporting organ and tissue donation. We hope that by working together your patient will be able to save and change the lives of others. Attached is the information from your patient's chart that is needed by TGLN in order to assess and offer out organs for transplantation. Pages are marked requesting that you either return the actual sheet or the **equivalent** from the patient's medical chart.

If you have any difficulty or questions regarding this package, please do not hesitate to contact the Provincial Resource Centre (PRC) and ask for the Clinical Services Coordinator (CSC) that is looking after the patient. Your hard work in making this happen is truly appreciated by TGLN, the donor family and most certainly the recipients of these lifesaving gifts.

Provincial Resource Centre Contact Information:

PRC Toll free Telephone #: 1-888-603-1399 (available 24/7)

PRC Toll Free Fax: 1-866-557-6100

PRC Toll Free Fax (Back up): 1-877-964-2634

CSC Reminders:

- 1) **Ensure each page has TGLN number**
- 2) **Please upload returned documentation**
- 3) **Please document the name of the nurse(s) in the donor chart**

Package Contents

Some pages need to be completed, signed and returned to TGLN via fax (i.e. Physical Assessment) but for other items you may choose to send an equivalent copy from the donor's chart (i.e. Lab work).

General Requirements

- | | |
|--|----------|
| <input type="checkbox"/> Supporting Documentation for NDD or DCD | pg 3 |
| <input type="checkbox"/> ABO | pg 4 |
| <input type="checkbox"/> Organ Physical Assessment | pg 5 & 6 |
| <input type="checkbox"/> Organ Physical Examination | pg 7 |
| <input type="checkbox"/> Lab Profile – Chemistry | pg 8 |
| <input type="checkbox"/> Lab Profile - CBC | pg 9 |
| <input type="checkbox"/> Flowsheet | pg 10 |
| <input type="checkbox"/> Blood Product/Colloid Administration | pg 11 |
| <input type="checkbox"/> Hemodilution Calculation | pg 12 |
| <input type="checkbox"/> Lab Profile – Toxicology | pg 13 |
| <input type="checkbox"/> Cultures | pg 14 |
| <input type="checkbox"/> Medications/Other Drugs | pg 15 |
| <input type="checkbox"/> Chest XRay | pg 16 |

Renal

- | | |
|-------------------------------------|-------|
| <input type="checkbox"/> Urinalysis | pg 17 |
|-------------------------------------|-------|

Pulmonary

- | | |
|---|-------|
| <input type="checkbox"/> Arterial Blood Gases | pg 18 |
| <input type="checkbox"/> Bronchoscopy Worksheet | pg 19 |

Cardiac

- | | |
|---|-------|
| <input type="checkbox"/> Echocardiogram Worksheet | pg 20 |
| <input type="checkbox"/> ECG | pg 21 |

Reference

- | | |
|---|-----------|
| <input type="checkbox"/> Physician's Orders for Adult Organ Donation Template | pg 22- 29 |
|---|-----------|

PLEASE SEND THE FOLLOWING DOCUMENTATION TO TGLN:

Brain death declarations (NDD only)

Withdrawal of life support note (DCD only)

**Consent to Interventions for the Purpose of
Organ Donation after Cardio-Circulatory Death (DCD only)**

ABO

MRN:

Name:

DOB:

TGLN #:

ABO:

SUBTYPE:

**PLEASE SEND HARDCOPY OF ABO
WITH THESE IDENTIFIERS**

(Subtype only required if blood type "A" or "AB")

PLEASE RETURN COMPLETED

ORGAN PHYSICAL ASSESSMENT

Body Identified By

Patient's Nurse:

Toe Tag:

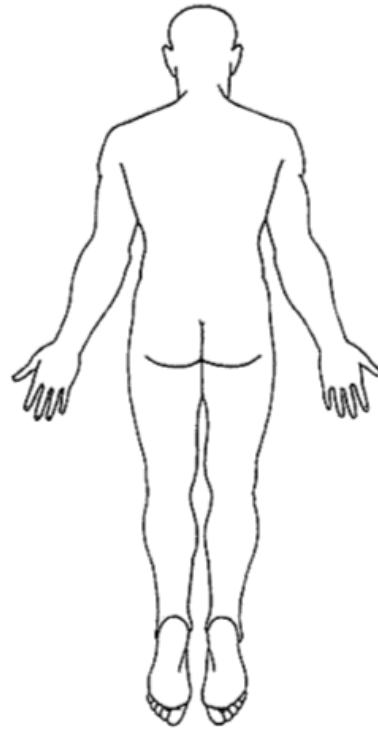
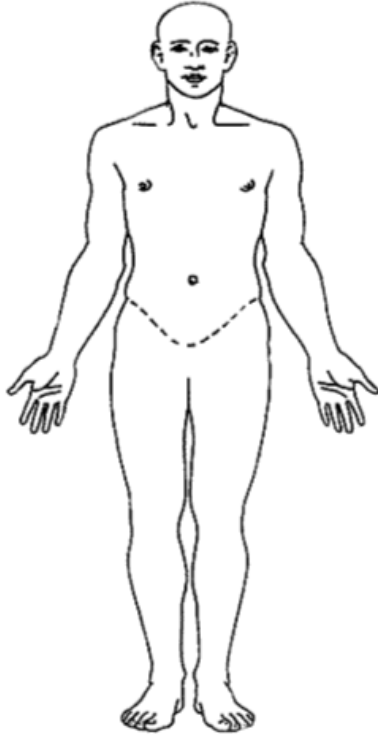
Wrist Band:

Other:

Person Identifying: _____

Examination Performed By: _____

Date-Time: --/-- --:--



ASSESSMENT KEY

- | | | | |
|-----------------------|-------------------------------|----------------------------|-------------------------------------|
| 1. ETT | 8. PA Cath Line | 15. Temperature Probe | 22. Dressing/Bandage |
| 2. Trach | 9. Track Marks | 16. Surgical Scar/Incision | 23. Cast/Ortho Device |
| 3. Chest Tube | 10. Other IV Site | 17. Other Scars | 24. Body Piercing |
| 4. NG/OG/Feeding Tube | 11. Drains | 18. Laceration/Wound | 25. Tattoo |
| 5. Foley | 12. Peripheral IV | 19. Abrasion | 26. Skin Lesion/Rash/Genital Lesion |
| 6. Arterial Line | 13. Needle Site: Hospital | 20. Bruise/Contusion | 27. Other |
| 7. Central Line | 14. Needle Site: Non-Hospital | 21. Fracture/Dislocation | 28. Unremarkable |

ASSESSMENT KEY

- | | |
|---|----------------------------|
| 1. ETT: <input type="checkbox"/> | 16. Surgical Scar/Incision |
| 2. Trach: <input type="checkbox"/> | |
| 3. Chest Tube: <input type="checkbox"/> | |
| 4. NG/OG/Feeding Tube: _____ | |
| 5. Foley | |

Date Generated: 02/07/2016 20:32 EDT Physical Assessment Page 1 of 2
Version #: 2016.1.1.2

Staff Completing: _____



PLEASE RETURN COMPLETED

ORGAN PHYSICAL ASSESSMENT

6. Arterial Line: <input type="checkbox"/>	17. Other Scars: -----
7. Central Line: <input type="checkbox"/>	18. Laceration/Wound: -----
8. PA Cath Line: <input type="checkbox"/>	19. Abrasion: -----
9. Track Marks: <input type="checkbox"/>	20. Bruise/Contusion: -----
10. Other IV Site: -----	21. Fracture/Dislocation: -----
11. Drains: -----	22. Dressing/Bandage: -----
12. Peripheral IV	23. Cast/Ortho Device: -----
13. Needle Site: Hospital	24. Body Piercing: -----
14. Needle Site: Non-Hospital	25. Tattoo: -----
15. Temperature Probe	26. Skin Lesion/Rash/ Genital Lesion: -----
	27. Other: -----
	28. Unremarkable: <input type="checkbox"/>

Comments:

Please also record:

Weight _____ kg Actual

Height _____ cm Actual



PLEASE RETURN COMPLETED

ORGAN PHYSICAL EXAMINATION

Evidence of:	Trauma to tissue retrieval sites:	-	Jaundice:	-
	Non-medical injection of drugs:	-	Enlarged lymph nodes:	-
	Infection:	-	Insertion Trauma/Perianal Lesions::	-
	Genital lesions:	-	White spots in mouth:	-
	Blue/purple spots:	-	Unable to Visualize Oral Cavity (see comments)	<input type="checkbox"/>
	Palpable Masses:	-	Abnormal Ocular Findings (icterus/scarring):	-

PLEASE RETURN COMPLETED OR EQUIVALENT

LAB PROFILE - CHEMISTRY

Date	--/------
Time	--:--
* Na+ (135 - 147)	-----
↓ K+ (3.5 - 5)	-----
* Cl- (96 - 106)	-----
Bicarb	-----
* Urea (3.0 - 7.0)	-----
* Creatinine (30 - 90)	-----
eGFR	-----
Creatinine Clearance	-----
* Glucose (4.0 - 6.0)	-----
* Calcium (2.20 - 2.60)	-----
Ionized Calcium	-----
* Mg	-----
* Phosphorus	-----
Lactate	-----
* Total Bili	-----
Direct/Conjugated Bili	-----
Indirect/Unconj. Bili	-----
* SGOT (AST) (< 36)	-----
* SGPT (ALT) (< 50)	-----
Alk Phos	-----
GGT (0 - 20)	-----
Albumin	-----
Total Protein	-----
LDH	-----
* PT (9 - 11.5)	-----
* INR	-----
PTT (24-36)	-----
CK (M <255, F <150)	-----
CK/MB	-----
CPK	-----
CPK Index (<2.5%)	-----
Total MB	-----
Troponin-I	-----
Troponin-T	-----
↓ Amylase	-----
* Lipase (0-80)	-----
* Hgb A1C (4.0 - 5.9)	-----
-----	-----
-----	-----
-----	-----
-----	-----
-----	-----

** indicates that TGLN must obtain these values for Health Canada purposes*

If any of these tests are not available at your hospital, please inform TGLN

Amylase OR Lipase required

Comments:



PLEASE RETURN COMPLETED *OR* EQUIVALENT

LAB PROFILE - CBC

Date-Time	--/-- --:--
WBC	-----
RBC	-----
Hgb (M 140 - 180, F 120 - 160)	-----
Hct (M 0.42 - 0.52, F 0.37 - 0.47)	-----
Platelets	-----



PLEASE RETURN COMPLETED OR EQUIVALENT

FLWSHEET

Date-Time	--/--/----
VITAL SIGNS	
Hypotension	--/--/----
Hypertension	--/--/----
BP	--/--
MAP	-----
HR	--
Temperature	-- °C
Temperature Regulating Device	-----
CVP	-----
PA	--/--
PCWP	--
PAMP	--
CO/CI	--/--
SaO2%	-----
SVR	--
PVR	--
SVRI	--
SVV	--
RVSWI	--
LVSWI	--
Glucose checks	-----
-----	-----
-----	-----
-----	-----
-----	-----
VENT SETTINGS	
Mode	-----
Rate	-----
FIO2	-----
TV	-----
Peep	-----
PIP	-----
-----	-----
-----	-----
-----	-----
INTAKE	
Fluid / Additive	Dosage/Vol(mls)/Unit
-----/-----	--/--/-----
-----/-----	--/--/-----
-----/-----	--/--/-----
-----/-----	--/--/-----
-----/-----	--/--/-----
-----/-----	--/--/-----
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-----/-----	--/--/-----
-----/-----	--/--/-----
-----/-----	--/--/-----
-----/-----	--/--/-----
-----/-----	--/--/-----
Medications	Dosage/Vol(mls)/Unit
-----	--/--/-----
-----	--/--/-----
-----	--/--/-----



PLEASE RETURN COMPLETED OR EQUIVALENT

BLOOD PRODUCT/COLLOID ADMINISTRATION SUMMARY

Date-Time Completed	Blood/Colloid Type	Units	Volume mL
--/-- --:--	-----	--	--

Comments:



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PLEASE RETURN COMPLETED OR EQUIVALENT

**TGLN DONOR# _____

**Health Canada Requirement
(T) Tissue Requirement

Date Format: dd/mm/yyyy

**** HEMODILUTION CALCULATION #:** _____ *(Must be completed with every blood draw)*

Review patients chart for information about any transfusions 48 hours prior to collection:

- Yes, all information was reviewed prior to hemodilution calculation.
- No, all information was not reviewed prior to calculation. Specify why in the clinical notes.

Name: _____ Date: _____ Time: _____

RED BLOOD CELLS containing products infused in the 48-hr period prior to the sample evaluation time. Examples include: whole blood, packed red blood cells, and reconstituted blood.

COLLOIDS infused in the 48-hr period prior to the sample evaluation time. Examples include: fresh frozen plasma (FFP), albumin, dextran, pentaspan, platelets, cryoprecipitate and IV Total Parenteral Nutrition (TPN), aka Parenteral Hyperalimentation (PHA)

CRYSTALLOIDS infused in the 1-hr period prior to the sample evaluation time. Examples include: saline solution, lactated ringers, propofol, etc.
*Mannitol & 3% Saline vol x 3

PRODUCT	VOLUME	PRODUCT	VOLUME	PRODUCT	VOLUME
A		B		C	



PLEASE RETURN COMPLETED *OR EQUIVALENT*

LAB PROFILE - TOXICOLOGY

Serum Alcohol:	-----
Urine Toxicology:	-----



CULTURES

Please draw one set of blood, sputum & urine cultures q24h and inform TGLN of the date & time that the cultures are being drawn

Please inform the TGLN coordinator if there are any previous positive cultures



PLEASE RETURN COMPLETED *OR* EQUIVALENT

MEDICATIONS/OTHER DRUGS

Medication	Date-Time Started	Dosage	Dosage Unit	Peak Dose	Peak Dose Unit	Duration	Date-Time Stopped
-----	--/-- --:--	-----	-----	-----	-----	-----	--/-- --:--

Comments:



PLEASE RETURN COMPLETED *OR EQUIVALENT*

CXR			
Chest X-ray:	-----		
Date-Time:	dd/mm/yyyy - hh:mm	Result:	---
Affiliation/Hospital:		Status:	
Interpretation:			
<div style="border: 1px solid black; height: 50px;"></div>			



PLEASE RETURN COMPLETED OR EQUIVALENT

ABO: -----

522 University Avenue, Suite 900
TORONTO ON M5G 1W7 CA

LAB PROFILE - URINALYSIS

Date-Time	--/-- --:--
R&M/Dipstick	-----
Nitrates	-----
Color	-----
Appearance	-----
pH	-----
Spec. Grav.	-----
Protein	-----
Glucose	-----
Blood	-----
RBC	-----
WBC	-----
Ketones	-----
Casts	-----
Bacteria	-----
Epith	-----
Leukocyte	-----
-----	-----
-----	-----



PLEASE RETURN COMPLETED *OR EQUIVALENT*

ARTERIAL BLOOD GASES

Date-Time	pH	pCO2	pO2	BE	HCO3	O2Sat	FI02	Rate	TV	PEEP	PIP	Mode
--/--/-- --:--	--	--	--	--	--	--	--	--	--	--	--	--
Comments:	-----											



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**PLEASE CONFIRM WITH THE COORDINATOR IF THIS TEST IS REQUIRED
RETURN COMPLETED OR EQUIVALENT**

BRONCHOSCOPY WORKSHEET

Date: _____ Time: _____

Description	LEFT	RIGHT	N/A	Comments
Anatomy:				if abnormal, please describe findings:
Normal	<input type="checkbox"/>	<input type="checkbox"/>		
Abnormal	<input type="checkbox"/>	<input type="checkbox"/>		
Secretions:			<input type="checkbox"/>	
Bloody Secretions:			<input type="checkbox"/>	
Mild	<input type="checkbox"/>	<input type="checkbox"/>		
Moderate	<input type="checkbox"/>	<input type="checkbox"/>		
Severe	<input type="checkbox"/>	<input type="checkbox"/>		
Reaccumulation after suctioning	<input type="checkbox"/>	<input type="checkbox"/>		
Mucoid Secretions:			<input type="checkbox"/>	
Mild	<input type="checkbox"/>	<input type="checkbox"/>		
Moderate	<input type="checkbox"/>	<input type="checkbox"/>		
Severe	<input type="checkbox"/>	<input type="checkbox"/>		
Reaccumulation after suctioning	<input type="checkbox"/>	<input type="checkbox"/>		
Purulent Secretions:			<input type="checkbox"/>	
Mild	<input type="checkbox"/>	<input type="checkbox"/>		
Moderate	<input type="checkbox"/>	<input type="checkbox"/>		
Severe	<input type="checkbox"/>	<input type="checkbox"/>		
Reaccumulation after suctioning	<input type="checkbox"/>	<input type="checkbox"/>		
Airway Erythema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	if yes, please describe below:
Obvious Aspiration:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BAL Sent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gram Stain Results:

Any Additional Comments:

Physician who interpreted and reported results: _____

Signature: _____ Status (i.e. resident): _____ Hospital: _____

Name: _____

**PLEASE CONFIRM WITH THE COORDINATOR IF THIS TEST IS REQUIRED
RETURN COMPLETED OR EQUIVALENT**

Echocardiogram WORKSHEET

Date: _____ Time: _____

Inotropes (During the Exam) (mcg/kg/min):

Levophed _____	Vasopressin _____
Dobutamine _____	Epinephrine _____
Dopamine _____	Other _____

Pulmonary Pressure: _____ mmHg T4 Given: Yes No
 CVP _____ mmHg If yes, amount _____ Time: _____

Atrium:

LA Dimension _____ cm² RA Dimension _____ cm²
 ASD Present Absent
 PFO Present Absent

Right Ventricle:

Contractility Normal Moderate Hypokinesia Severe Hypokinesia
 Tricuspid Regurgitation I II III IV
 RVSP/Pulmonary Pressure: _____ mmHg

Left Ventricle:

Ejection Fraction _____ %
 Shortening Fraction _____ %
 Contractility Normal Moderate Hypokinesia Severe Hypokinesia
 Regional WMA anterior apical lateral inferior posterior septal
 LVEDD _____ mm
 LVESD _____ mm
 Septal Thickness _____ mm
 Post Wall Thickness _____ mm
 Left Ventricular Hypertrophy Present Absent

Aortic Valve:

Normal Sclerotic Stenosis Bicuspid
 Aortic Valve gradient _____ AVA _____
 Aortic Regurgitation I II III IV

Mitral Valve:

Normal Sclerotic Stenosis Bicuspid
 Mitral Regurgitation I II III IV
 Mitral Annular Calcification mild Moderate Severe

Any Additional Comments:

Name: _____ Status: _____ Affiliation: _____ Signature: _____



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**PLEASE CONFIRM WITH THE COORDINATOR IF THIS TEST IS REQUIRED
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Please send a copy of the most recent ECG from the patient's chart



Trillium Gift of Life Network
522 University Ave., Suite 900
Toronto, ON
M5G 1W7
Tel: 416 363-4001
Fax: 416 363-4002
www.giftoflife.on.ca

Fall | 2013

Physician's Orders for Adult Organ Donation: Template

Standard Monitoring

1. List known allergies
2. Continuous cardiac monitoring and pulse oximetry
3. Vital signs q1h
4. Document height _____ cm, weight _____ kg, chest circumference _____ cm, and abdominal girth _____ cm
5. Warming blanket to maintain T° 35.5 C-37.0 C
6. Urine catheter to straight drainage, hourly intake and output
7. Nasogastric tube to straight drainage; if not using for nutritional support
8. Central venous pressure (CVP) monitoring
9. Arterial blood pressure q1h
10. Continue standard eye care

Laboratory Investigations

1. CBC, electrolytes, BUN, Cr, glucose, lactate, Ca, Mg, PO₄, albumin, t-protein, AST, ALT, ALP, amylase, lipase, bilirubin (total and direct), INR, PTT now and q4h
2. CK, CK-MB now and q4-8h
3. Troponin I or T now and q8h
4. ABG now and q4h, see respiratory section
5. Blood for Group and Screen to Blood Bank; place hard copy of result on chart
6. Blood and urine for toxicology screen unless possibility of overdose ruled out by MD or previously completed
7. Urinalysis now and q24h
8. Central venous oximetry q2-4h; titrate therapy to central MVO₂ ≥ 60%

Microbiology

1. Daily blood cultures for C&S now and q24h
2. Daily urine cultures for C&S now and q24h
3. Daily endotracheal tube (ETT) cultures for C&S now and q24h
4. Bronchoscopy and bronchial alveolar lavage gram stain and culture x 1 and prn
5. Antibiotics for presumed or proven infection



Hemodynamic Monitoring and Therapy

Targets:

1. Heart rate $\geq 60 \leq 120$ bpm
2. Systolic blood pressure (SBP) $\geq 100 \leq 160$ mmHg
3. Mean arterial blood pressure (MAP) $\geq 70 \leq 90$ mmHg
4. Central venous pressure (CVP) $\geq 6 \leq 10$ mmHg
5. Central or Mixed venous $M_vO_2 \geq 60\%$
6. If PA catheter in situ:
 - a. CI > 2.4 L/min/m²,
 - b. SVR 800-1200 dynes/sec-cm⁵,
 - c. PCWP 6-10 mmHg,
7. Maintain Hgb ≥ 70 g/L

Cardiovascular

1. 12 lead EKG x 1 now and prn
2. Insert a subclavian or jugular central line for continuous central venous pressure monitoring
3. 2D transthoracic echocardiogram x 1 now (see Appendix 1 and 2)
 - a) If 2D echo ejection fraction $\leq 40\%$ then repeat echocardiography at q8-12hr intervals after first dose of L-thyroxine given
4. Consider insertion of a PA catheter if EF $\leq 40\%$ and/or secondary inotropes or vasopressors required for hypotension
5. See Appendix 3 for cardiac angiography considerations

Agents for Hypotension (therapies listed in order of recommended initiation)

1. IV bolus 250 mL of IV maintenance fluid over 10 minutes prn if SBP < 100 mmHg or MAP < 70 mmHg and CVP < 10 ; maximum 500 mL, then MD to reassess
2. Vasopressin IV infusion at 0-2.4 units/hr prn for SBP < 100 mmHg or MAP < 70 mmHg
3. Dopamine IV infusion at 5-10 mcg/kg/min prn for SBP < 100 mmHg or MAP < 70 mmHg and unresponsive to above interventions (omit if HR > 120)
4. Norepinephrine IV infusion at 0-20 mcg/min prn for SBP < 100 mmHg or MAP < 70 mmHg
5. Epinephrine IV infusion at 0-20 mcg/min prn for SBP < 100 mmHg or MAP < 70 mmHg

6. Phenylephrine (neo-synephrine) infusion 0-200 mcg/min prn for SBP < 100 mmHg or MAP < 70 mmHg

Agents for Hypertension(listed in order of recommended initiation)

Wean inotropes or vasopressors if infusing; start antihypertensives for SBP > 160 mmHg and/or MAP > 90 mmHg

1. Sodium nitroprusside IV infusion at 0-5 mcg/kg/min prn for SBP > 160 mmHg and/or MAP > 90 mmHg
2. Esmolol 100-500 mcg/kg IV bolus followed by 100-300 mcg/kg/min IV infusion prn for SBP > 160 mmHg and/or MAP > 90 mmHg
3. Nitroglycerin IV infusion at 0- 10 mcg/kg/min prn for SBP > 160 mmHg and/or MAP > 90 mmHg
4. Labetalol IV infusion at 0-2 mg/min; discontinue if HR < 65 prn for SBP > 160 mmHg and/or MAP > 90 mmHg

Respiratory

1. Chest x-ray q4h and prn
2. ABGs q4h and prn on FiO₂ 1.0
3. Bronchoscopy and bronchial alveolar lavage gram stain and culture x 1 and prn (see Appendix 4 for worksheet)
4. Routine ETT suctioning and repositioning as tolerated q2h and prn, head of bed elevated at 35-45 degrees
5. Salbutamol and ipratropium 8 puffs each q4h + q2h prn for wheezing
6. Mechanical ventilation targets:
 - a) Tidal volume (Vt) 6-8 ml/kg, positive end expiratory pressure (PEEP) 8-10 cm H₂O, peak inspiratory pressure (PIP) ≤ 30 cm H₂O
 - b) Attempt to maintain normalized arterial blood gases; pH 7.35-7.45, PaCO₂ 35-45 mmHg, PaO₂ ≥ 80 mmHg, O₂ sat ≥ 95%
7. Recruitment maneuvers and challenge arterial blood gases for potential lung donor q2-4h as tolerated:
 - a) Preoxygenate with FiO₂ 1.0 for 10 minutes
 - b) Sustained inflation with PEEP of 30cm H₂O x 30 sec
 - c) Maintain FiO₂ of 1.0 and return to maintenance ventilatory parameters;
 - d) Draw ABG 10 minutes post inflation;
 - e) Return to maintenance FiO₂ once complete;
 - f) Obtain CXR once completed



Fluids and Electrolytes

Targets:

- a) Urine output 0.5–3 ml/kg/hr
 - b) Serum sodium (Na) $\geq 130 \leq 150$ mmol
 - c) Normal ranges for potassium, calcium, magnesium, phosphate, and glucose
 - d) Blood glucose 6-10 mmol/L
-
1. NaCl 0.9% IV infusion for maintenance at _____ mL/hr
 2. If serum Na > 145 mmol/L evaluate for Diabetes Insipidus (see section on Diabetes Insipidus)
 3. Implement hospital standing order set for electrolyte imbalances or follow below:
 4. If $PO_4 < 0.65$ mmol/L then phosphate potassium 9 mmol phosphate IV in 100 mL NaCl or D5W over 4-6 hours
 5. If Ca corrected < 2.0 mmol/L or ionized Ca < 1.0 mmol/L then calcium gluconate 10 % 1 g IV in 100 mL NaCl or D5W over 30 minutes (central or peripheral)
 6. If Mg < 0.80 mmol/L then magnesium sulphate 1 g IV in 50-100 mL NaCl or D5W IV over 30 minutes (central or peripheral)
 7. If K < 3.9 and > 3.2 mmol/L then potassium chloride 20 mEq IV in 50-100 mL NaCl or D5W via **central line** over 1 hour
 8. If K ≤ 3.2 mmol/L then potassium chloride 40 mEq IV in 100 mL NaCl or D5W via **central line** over 2 hours

Glycemia and Nutrition

1. Initiate or continue nutritional support, when appropriate and possible
2. Initiate and titrate insulin infusion to maintain serum glucose 6-10 mmol/L
3. Stop enteral feeds on call to OR and empty gastric residuals; clamp NG

Endocrine and Metabolic

1. L-thyroxine 100 μ g IV x 1, then 50 μ g IV q12h or 20 μ g IV bolus followed by 10 μ g/hr IV infusion
2. Methylprednisolone 15 mg/kg (max 1 gm) IV q24hrs
3. Implement or continue hospital insulin nomogram/order set
4. N-acetylcysteine 600 mg IV bid x 4 doses if IV contrast planned



Diabetes Insipidus

1. Urine output > 4 ml/kg/hr, associated with:
 - a) Rising serum and/or Na ≥ 145 mmol/L and/or
 - b) Rising serum osmolarity ≥ 300 mosM and/or
 - c) Decreasing urine osmolarity ≤ 200 mosM
 - d) Specific Gravity < 1.010

Diabetes Insipidus therapy:

1. Titrate therapy to urine output ≤ 3 ml/kg/h
 - a) DDAVP 4 mcg IV q6h prn
 - b) IV vasopressin infusion at _____ units/h (minimum 0.5 units/h and maximum of 2.4 units/h)
 - c) If Na > 145 change maintenance IV to 0.45% NaCl or D5W
 - d) IV maintenance bolus to maintain CVP 6-10 mmHg



References

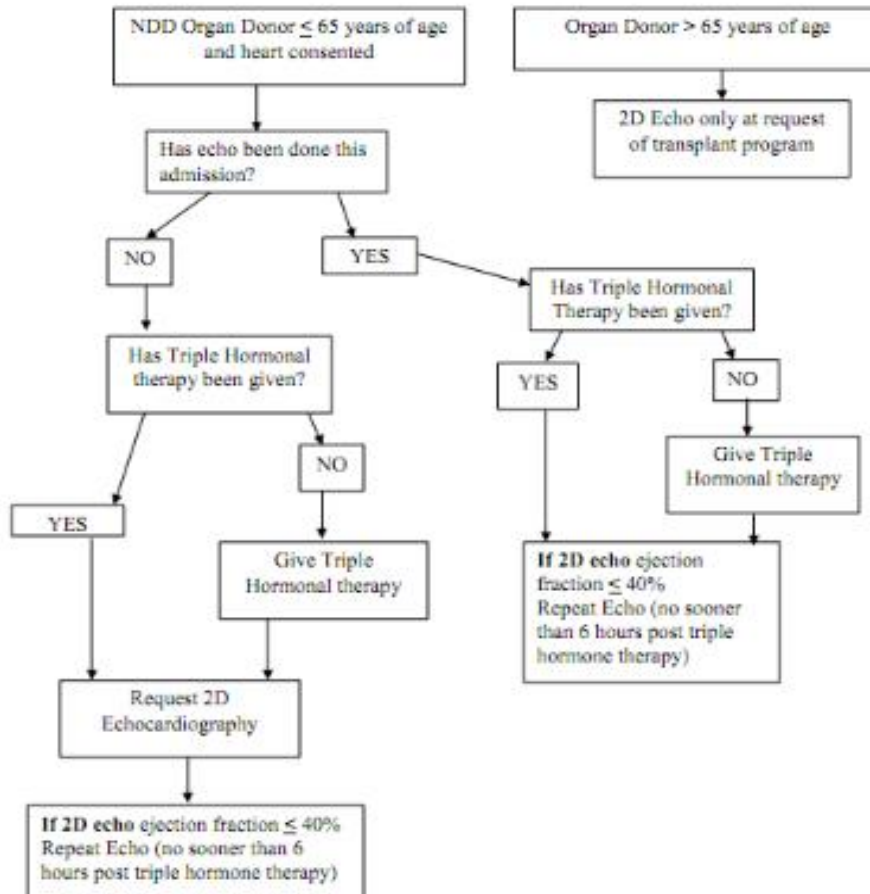
Canadian Council for Donation and Transplantation. (2004). Medical management to optimize donor organ potential: A Canadian forum: Report and recommendations. February 23-25, 2004, Mont Tremblant, P.Q.

Frontera, J.A., & Kalb, T. (2010). How I manage the adult potential organ donor: Donation after neurological death (Part 1). *Neurocritical Care*, 12, 103-110.

Mascia, L., Pasero, D, Slutsky, A.S., Arguis, M., J., Berardino, M., Grasso, S., et al. (2010). Effect of lung protective strategy for organ donors on eligibility and availability of lungs for transplant. *Journal of the American Medical Association*, 304(23), 2620-2627.

Nice Sugar Study Investigators. (2009). Intensive versus conventional glucose control in critically ill patients. *The New England Journal of Medicine*, 360 (13), 1283-1297.

Appendix 1: Decision-making Algorithm for Risk Factors Requiring Echocardiography



Appendix 3: Decision-making Algorithm for Risk Factors Requiring Cardiac Angiography

