Patient Name: Releaseone Organ
ABO: ---------

UNOS #: ---------
OPO #:
MRN: 654321

REFERRAL WORKSHEET

HOSPITAL INFORMATION

How did you learn of this case? Donor Hospital Notification
Referral Taken By: Redacted **Referral Date-Time:** 04/06/2020 10:43 EDT
Caller First: Redacted **Last:** Redacted **Title:** PTC
Phone: **Ext.:** ---------
Referring Hospital: **Code:** OHAC
Unit: **Unit Detail:** ---------
Special Instructions:

IMPORTANT!!! Please Complete Release of Deceased Form and have it with you prior to taking patient to OR. - 5/30/2019

Family Members in OR on DCD. Hospital Policy is 2 members of the family only. If there is more than 2 family members OR has agreed to let family rotate in and out of OR** - 5/30/2019

Coroner:
For release of deceased, please contact the referring unit (or if from ED, the Charge Nurse) and security (Redacted). Can call the unit first to give release then request to be transferred to Security.

Eligible for all Research for Redacted

Remote and onsite EMR Access available via CareLink Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Must use Redacted if onsite - no system passwords are assigned to Redacted staff so hospital computers cannot be used.
Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted

Updated scrub process The two scrub ex cards along with the locker room swipe access card will be located in the Redacted envelope in the lock box in the tall, cream colored cabinet behind the control desk. Please return all three cards in envelope to control desk once case is completed. Scrubs MUST be returned to the scrub ex machine using one of these cards as well. DO NOT simply deposit in dirty laundry as Redacted account will not be credited. **

Women's locker #72 - combination is Redacted; or in the men's locker #30 - combination is Redacted. Locker rooms are locked, but the swipe access card is available in the lock box in the tall, cream colored cabinet behind the Control Desk.

Organ Recovery OR:
Hospital has their own Balfour that will be used for all cases. Contact OR ASAP to notify of case and continue with updates on anticipated OR time. OR ext. Redacted. When OR time is scheduled, alert security alerted that team(s) will be arriving at the approximate time and will need escorted from the ED to the OR. Following the OR, communicate with OR staff to determine whether they or Redacted staff will be returning the patient's chart to the unit.

Infection Prevention Staff available 24-hours/day for review of potential donor's infection history: Redacted Redacted Redacted Redacted Redacted Redacted Redacted Redacted

Hospital Services on Site? --
First Responder: ---------

PATIENT INFORMATION

Last Name: Organ **First:** Releaseone **Middle:** ---------
Nickname: ---------
DOB: 02/20/1980 **Age:** 40 Years **Sex:** Male
Height: --------- **Weight:** --------- **BMI:** --
UNOS Donor ID: --------- **MRN:** 654321 **SSN:** 789-45-6123
Race: White: Not Specified/Unknown
Admission Date-Time: 04/05/2020 14:00 EDT
Referred on vent? Yes **Referral Type:** O
Removed from vent prior to referral? No
Previously on a vent? ---------
Date-Time of Extubation: --/--/---- --:--

REFERRAL WORKSHEET

Was Referral Timely For Organ Donation? Yes
Was Referral Timely For Tissue Donation? --
Clinical Trigger Met Date-Time: --/--/---- --:--
UNOS Cause of Death: Anoxia **If Other, Specify:** ---------
OPO Cause of Death: ---------
Circumstances of Death: --------- **Mechanism of Death:** ---------
Admission Diagnosis: Acute respiratory failure 2/2 pancreatitis
Clinical Course/Circumstances Surrounding Death:
Weight 100 kg
History of... **HIV?** No **HBV?** No **HCV?** No **Sepsis?** No **IVDA?** No
Signs/symptoms of systemic infection? --
Donor Designation: Not Available: Minor child
Downtime information: ---------
Approach Prior to Referral: ☐
Att. MD: --------- **Is the patient listed under trauma service?** ---------
Missed Organ Potential (For QS/MRR staff use Only): ☐

PRELIMINARY TISSUE SCREENING INFORMATION

Death Date-Time: --/--/---- --:-- **Whole Body Referral:** ☐
IV fluid given in the last hour? --
Blood given in the last 48 hours? --
Person contacted NOT to release the body: -- **Name:** ---------

M.E. INFORMATION

M.E. Case? --------- **Contact Name:** --------- **Contact Phone:** ---------
Autopsy: ---------
Restrictions / Denial reason(s):

M.E./Other Special Requests:

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

Donor Name:	Releaseone Organ		
Place of Interview:	Hospital	**Date-Time Interviewed:**	04/13/2020 18:10 EDT
Person Conducting Interview and Completing Form:			
Person Interviewed:	John Doe	**Relationship to Potential Donor:**	Spouse
Address:	123 Cherry Lane Akron, OH 44312 United States		
Phone:	330-987-6543	**Phone Type:**	Cell
E-Mail:	johndoe@email.com		
Person Interviewed:	---------	**Relationship to Potential Donor:**	---------
Address:	---------		
Phone:	---------	**Phone Type:**	---------
E-Mail:	---------		

I want to advise you of the sensitive and personal nature of some of these questions. They are similar to those asked when someone donates blood. We ask these questions for the health of those who may receive her/his* gift of donation. I will read each question and you will need to answer to the best of your knowledge with a "Yes" or "No."

** The interviewer should mix the appropriate pronoun with other terms with which the historian can relate: the donor's given name; their nickname; inserting "your" father, mother, husband, wife, sister, brother, daughter, son, or child (as indicated).*

1. Where was she/he* born?
Ohio

2. What was her/his* occupation?
Wife

3. Did she/he* have any health problems due to exposure to toxic substances such as pesticides, lead, mercury, gold, asbestos, agent orange, etc.?	No	3a. Describe toxic substance and treatment. --------
4a. Did she/he* have a family physician or a specialist?	Yes	4a(i). When was her/his* last visit? Last Week 4a(ii). Why? Cough 4a(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.): Dr James
4b. Did she/he* use a medical facility such as a clinic or urgent care center?	Yes	4b(i). When was her/his* last visit? Last Week 4b(ii). Why? Cough 4b(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.): Stat Care
5a. Did she/he* take any prescription medication recently or on a regular basis?	No	5a(i). What was it and/or what was it used for? -------- *Was a steroid, such as prednisone named?* -------- *If a steroid, such as prednisone, ask:* 5a(ii). How long? -------- 5a(iii). What was the dose? --------

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

5b. Did she/he* take any non-prescribed medication or dietary supplements?	No	5b(i). What was it and/or what was it used for? ---------
6. Did she/he* recently have any symptoms such as: *If any answer in question 6. is "yes,"* ask "when" *this occurred and* "describe symptoms and reasons," *if known.*		
6a. a fever?	No	6a(i). When? --------- 6a(ii). Describe the fever and reasons. ---------
6b. cough?	Yes	6b(i). When? Last Week 6b(ii). Describe the cough and reasons. Dry Hoarse, chest cold
6c. diarrhea?	No	6c(i). When? --------- 6c(ii). Describe diarrhea and reasons. ---------
6d. swollen lymph nodes or glands in the neck, armpits or groin?	No	6d(i). When? --------- 6d(ii). Describe swollen lymph nodes or glands and reasons. ---------
6e. weight loss?	No	6e(i). When? --------- 6e(ii). Describe how much weight loss and reason(s). ---------
6f. a rash?	No	6f(i). When? --------- 6f(ii). Describe the rash and reasons. ---------
6g. sores in the mouth or on the skin?	No	6g(i). When? --------- 6g(ii). Describe the sores and reasons. ---------
6h. night sweats?	No	6h(i). When? --------- 6h(ii). Describe night sweats and reasons. ---------
6i. severe headache?	No	6i(i). When? --------- 6i(ii). Describe the severe headache and reasons. ---------
6j. rapid decline in mental ability?	No	6j(i). When? --------- 6j(ii). Describe rapid decline in mental ability and reasons. ---------

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

6k. seizures?	No	6k(i). When? --------- 6k(ii). Describe seizures and reasons. ---------
6l. tremors?	No	6l(i). When? --------- 6l(ii). Describe tremors and reasons. ---------
6m. difficulty walking?	No	6m(i). When? --------- 6m(ii). Describe difficulty walking and reasons. ---------
7. Did she/he* have any allergies?	Yes	7a. What was she/he* allergic to? Pollen 7b. Describe reaction: Sneezing
8. Did she/he* know anyone who had a smallpox vaccination?	No	8a. Was **that person** vaccinated within the past two months? --------- 8a(i). *If yes,* Did she/he* have contact with this person which includes touching the vaccination site, handling bandages that cover it, or handling bedding, clothing, or any other material that came in contact with the vaccination site? --------- 8a(i)a. *If yes,* Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? --------- 8a(i)a(i). *If yes,* Explain: ---------
9. In the past **12 months** was she/he* in lockup, jail, prison, or any juvenile correctional facility?	No	9a. How long? --------- 9b. Where? --------- 9c. Why? ---------

LAB PROFILE - URINALYSIS

Date-Time	--/--/---- --:--
Color	---------
Appearance	---------
pH	---------
Spec. Grav.	---------
Protein	---------
Glucose	---------
Blood	---------
RBC	---------
WBC	---------
Ketones	---------
Casts	---------
Bacteria	---------
Epith	---------
Leukocyte	---------
Albumin/Creatinine Ratio (ACR)	---------
---------	---------
---------	---------

Comments:

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

10. In the past **12 months** was she/he* bitten or scratched by any pet, stray, farm, or wild animal?	No	10a. What kind of animal? --------- 10b. When? --------- 10c. Did she/he* receive any medical treatment? --------- 10c(i). *If yes,* By whom? --------- 10d. Was the animal suspected of having rabies? --------- 10e. Was the animal quarantined or tested? --------- 10e(i). Which one? --------- 10e(ii). *If yes to tested,* What was the result? ---------
11. In the past **12 months** was she/he* told by a healthcare professional that they had a West Nile virus infection?	No	11a. When was she/he* diagnosed? --------- *Did this occur within the past 4 months?* --------- 11a(i). *If this occurred within the past 4 months ask:* What was the name of the doctor/clinic? ---------
12. In the past **12 months** did she/he* have any shots or immunizations, such as for the flu, MMR, yellow fever, hepatitis B, etc.?	No	12a. When? --------- 12b. What kind was it? --------- *Was smallpox/vaccinia named?* --------- *If smallpox/vaccinia is named, ask these questions:* 12b(i). Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? --------- 12b(i)a. *If yes,* When did these symptoms resolve? --------- 12b(ii). Did the scab fall off or was it picked off? --------- 12b(ii)a. When? ---------
This is a reminder these are standard questions we ask in every interview. Answer to the best of your knowledge with a "Yes" or "No."		

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

13. In the past **12 months** did she/he* get a tattoo, touch up of an old tattoo, or permanent makeup?	No	13a. Were shared or non-sterile instruments, needles or ink used? --------- 13b. Was the procedure performed outside of the United States or Canada? --------- 13b(i). *If yes,* Where? ---------
14. In the past **12 months** did she/he* have acupuncture, ear or body piercing?	No	14a. Were shared or non-sterile instruments or needles used? --------- 14b. Was the procedure performed outside of the United States or Canada? --------- 14b(i). *If yes,* Where? ---------
15a. In the past **12 months** did she/he* live with a person who has hepatitis?	No	15a(i). What type of hepatitis did **that person** have? --------- 15a(ii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin? ---------
15b. In the past **12 months** did she/he* live with a person who has tuberculosis?	No	15b(i). Describe what happened and when. ---------
16. In the past **12 months** did she/he* come into contact with someone else's blood?	No	16a. Describe what happened and when: --------- 16b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis? ---------
17. In the past **12 months** did she/he* have an accidental needle-stick?	No	17a. Describe what happened and when: --------- 17b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis? ---------
As I described before, I want to remind you of the sensitive and personal nature of some of these questions. For medical and health reasons, we are required to ask these questions about all potential donors. Next, I will ask you about her/his* sexual history.		
18. In the past **12 months** did she/he* have a sexually transmitted infection such as syphilis, gonorrhea, chlamydia, or genital ulcers, herpes, or genital warts?	No	18a. What was it? ---------
For the next part, sexual activity and sex refer to any method of sexual contact including vaginal, anal, and oral. **I will read each question and you should answer to the best of your knowledge with a "Yes" or "No."**		
19. In the past **5 years** was she/he* sexually active, even once?	No	*If yes, complete the following questions (19a. to 19g.)* **For the following set of questions, think about the past 5 years:** 19a. Did she/he* have sex in exchange for money or drugs? ---------

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19a(i). *If yes,*
When?

Was the donor Male or Female?

19b. **MALE DONOR only:** Did he have sex with another male?

19b(i). *If yes,*
When?

19d. **FEMALE DONOR only:** Did she have sex with a male who had sex with another male?

19d(i). *If yes,*
When?

19c. Did she/he* have sex with a person who has had sex in exchange for money or drugs?

19c(i). *If yes,*
When?

19e. Did she/he* have sex with a person who used a needle to inject drugs that were not prescribed by their own doctor?

19e(i). *If yes,*
When?

19f. Did she/he* have sex with a person who has received medication for a bleeding disorder such as hemophilia?

If yes,

19f(i). Do you know the name of the medication?

19f(i)a. *If yes,*
What was it?

19f(ii). Was the medication human derived?

19f(iii). When was it used?

19g. Did she/he* have sex with a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV?

If yes,

19g(i). Which virus and when?

19g(ii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin?

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

20. In the past **5 years,** did she/he* receive medication for a bleeding disorder such as hemophilia?	No	20a. When? --------- 20b. What was the reason? --------- 20c. Do you know the name of the medication? --------- 20c(i). *If yes,* What was it? --------- 20d. Was the medication human derived? ---------
21. Did she/he* **EVER** use or take drugs, such as steroids, cocaine, heroin, amphetamines, or anything **NOT** prescribed by her/his* doctor?	No	21a. What was it? --------- 21b. How often and how long was it used? --------- 21c. When was it last used? --------- 21d. Were needles used? --------- 21d(i). *If no,* How was it taken? ---------
22a. Did she/he* **EVER** have a transplant or medical procedure that involved being exposed to live cells, tissues or organs from an animal?	---------	22a(i). Explain: ---------
22b. Did she/he* live with, or have sex with, a person who had?	---------	22b(i). Explain: ---------
23. Was she/he* **EVER** told by a physician that she/he* had a disease of the brain or a neurological disease such as Alzheimer's, Parkinson's, multiple sclerosis, or epilepsy?	No	23a. What was she/he* told by a physician? ---------
24. Was she/he* **EVER** refused as a blood donor or told not to donate?	No	24a. What was the reason? ---------
25. Did she/he* **EVER** have any kind of surgery?	Yes	25a. What kind? Tonsillectomy 25b. Where? Akron 25c. When? 1991

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

26. Did she/he* **EVER** travel or live outside of the United States or Canada?	Yes	26a. Where? Mexcio 26b. When and for how long? 5 years ago; 1 week 26c. Did she/he* **EVER** receive a blood transfusion or other medical treatment outside of the United States or Canada? No *If yes,* 26c(i). What occurred (which one)? --------- 26c(ii). Describe where and when: --------- *If international travel or residency is extensive, be aware of query regarding vaccinations or other shots (within the past 12 months) at question #12.*
27. Was she/he* **EVER** a U.S. military member, a civilian military employee, or a dependent of either?	No	27a. Did she/he* ever live or work on a U.S. military base outside the United States? --------- *If yes,* 27a(i). In which country or countries? --------- 27a(ii). When? --------- *Did this occur between 1980 and 1996 in Europe?* --------- 27a(ii)a. *If yes:* How long? *(estimate total time)* --------- *If in the military in the past 12 months, be aware of query regarding vaccinations or other shots at question #12.*
28. Did she/he* **EVER** use or take growth hormone?	No	28a. When was it used? --------- 28b. What kind was it? ---------
29. Did she/he* **EVER** have a positive or reactive test for:		
29a. the HIV/AIDS virus?	No	29a(i). Explain: ---------
29b. hepatitis?	No	29b(i). Explain: ---------
29c. HTLV-I or HTLV-II?	No	29c(i). Explain: ---------
29d. *T. cruzi* or told she/he* has Chagas' disease?	No	29d(i). Explain: ---------
30. Did she/he* **EVER** have liver disease or hepatitis?	No	30a. What kind? --------- 30b. When? ---------

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

31. Did she/he* **EVER** have malaria?	No	31a. When? --------- 31b. Where was she/he* treated? ---------
32. Did she/he* **EVER** have cancer?	No	32a. What type? --------- *Was skin cancer named?* --------- 32a(i). *If skin cancer:* What kind? --------- 32b. When was it diagnosed? --------- 32c. Describe when and where surgery, radiation, or chemotherapy occurred: --------- 32d. Was the cancer considered cured? --------- 32d(i). *If yes,* When? ---------
33. Did she/he* **EVER** smoke?	No	33a. What was it? --------- *Was cigarettes named?* --------- 33a(i). *If cigarettes:* How many packs per day? --------- 33b. How many years? --------- 33c. Did she/he* quit? --------- 33c(i). *If yes,* When? ---------
34a. Did she/he* **EVER** have lung disease such as asthma, COPD, or emphysema?	No	34a(i). Explain: ---------
34b. Did she/he* **EVER** have tuberculosis, or a positive skin or blood test for tuberculosis?	No	34b(i). Did she/he* receive treatment? --------- *If yes,* 34b(i)a. When? --------- 34b(i)b. How long? ---------

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

35. Did she/he* **EVER** drink alcohol?	No	35a. What type? --------- 35b. How often? --------- 35c. How much? --------- 35d. How long? ---------
36. Did she/he* **EVER** have diabetes?	No	36a. For how many years? --------- 36b. Was it treated? --------- 36b(i). *If yes,* How? ---------
37a. Did she/he* **EVER** have kidney disease, kidney stones, or frequent kidney infections?	No	37a(i). What did she/he* have? --------- 37a(ii). When? ---------
37b. Was she/he* **EVER** treated with dialysis?	No	37b(i). Was it peritoneal dialysis or hemodialysis? --------- 37b(ii). When? ---------
38. Did she/he* **EVER** have high blood pressure or high cholesterol?	No	38a. Which one (or both)? --------- 38b. For how many years? ---------
39. Did she/he* **EVER** have a heart attack or heart disease, such as a weak heart, a heart valve problem or an infection involving the heart?	No	39a. Explain: --------- 39b. How was it treated? ---------
40. Did she/he* **EVER** have circulation problems of the legs, such as varicose veins, blood clots, leg ulcers, or skin discoloration of the feet or ankles?	No	40a. Explain: ---------
41. Did she/he* **EVER** have an autoimmune disease such as systemic lupus erythematosis, rheumatoid arthritis, sarcoidosis, etc.?	No	41a. What was it? --------- 41b. Did she/he* take steroids? --------- *If yes, complete 5a(ii) and 5a(iii).*

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

42. Did she/he* **EVER** have any eye problems, procedures, or surgery?	No	42a. *If yes to eye problems:* What kind of eye problems? --------- 42b. *If yes to eye surgery or procedures:* What kind of surgery or procedure was performed and why? --------- 42c. Which eye(s)? --------- 42d. What is the name and/or phone number of her/his* eye doctor or eye clinic? ---------
43. Did she/he* or **any** of her/his* relatives have Creutzfeldt-Jakob disease, which is also called CJD or variant CJD?	No	43a. Who did? --------- 43a(i). *If a relative,* Is this person a blood relative? *(Note: The definition of blood relative is a person who is related through a common ancestor and not by marriage or adoption)* --------- 43a(i)a. *If yes,* Which blood relative? --------- 43b. Is there a physician, relative, or other person who can provide more information? *(document discussion)* ---------
44a. Did her/his* family have a history of diabetes?	No	44a(i). Describe type of relative, such as mother, father, sister, brother, etc.: ---------
44b. Did her/his* family have a history of coronary artery disease, which is a buildup of plaque in the heart's arteries?	No	44b(i). Describe type of relative, such as mother, father, sister, brother, etc.: ---------
Final Questions		
45. Are there other medical conditions you are aware of that we have not discussed?	No	45a. Describe: ---------
46. Do you now have any concerns that her/his* donation should not proceed?	No	46a. Can you share your concerns? ---------
47. Regarding these questions, are there other people, including healthcare professionals, who may provide additional information?	No	47a. Name(s) and contact information: ---------
48. Do you have any questions about these questions?	No	48a. Document: ---------
*Note to interviewer: Question 49, the HIV-1 Group O Risk Question, must be asked if the test kit being used for HIV-1 **Ab** testing is not labeled to include HIV-1 Group O.* *Question 49 NOT skipped*		
49. Did she/he* **EVER** have sex with a person who was born in or lived in any country in Africa?	No	49a. When was the person born, or when did the person live, in Africa? --------- *Was this since 1977?* --------- 49a(i). *If since 1977:* What country were they from? ---------

CL6.0A DRAI – DONOR > 12 YEARS OLD 01-01-2015 - #1

ADDITIONAL NOTES

ELECTRONIC SIGNATURE

Person completing this form acknowledges all questions have been answered truthfully and to the best of their knowledge.

Electronically Signed By: Redacted **On:** 04/13/2020 18:14 EDT

FINAL ORGAN DISPOSITION

Organ Outcome: --------- ---------
Final Organ Disposition Date: --/--/---- --:--
Are there any critical deviances associated with this referral? --
if Yes: ---------
Are Any of These Reasons Why the Patient Did Not Become a Donor?

Not Formally Declared Brain Dead: ---------
DCD Potential: ---------
Medically Unsuitable: ---------
Family Declined: --
ME/Coroner Declined: --
Cardiac Arrested: --

Did this patient have donation potential? --
Reason: ---------
Referral Classification: ---------
Eligible/Imminent Exclusions

- ---------

Kidney

- ---------

Liver

- ---------

Heart

- ---------

Lung

- ---------

Comments:

DONOR INFORMATION

Referral Type: O
Tissue ID: --------- **UNOS Donor ID:** --------- **MRN:** 654321
Additional ID: ---------
Crossclamp Date-Time: --/--/---- --:--

Referring Hospital: Redacted Redacted Redacted Redacted Redacted Redacted Redacted
Unit: Redacted **Unit Detail:** ---------
Telephone #: Redacted **Fax #:** ---------
Transferred Reason: --------- **Transferred Date-Time:** --/--/---- --:--
Transfer Company: --------- **(Filtered by:** ---------)
Current Donor Location: Redacted Redacted Redacted Redacted Redacted Redacted Redacted
Unit: Redacted **Unit Detail:** ---------
Telephone #: Redacted **Fax #:** ---------
Admission Date-Time: 04/05/2020 14:00 EDT **Referral Date-Time:** 04/06/2020 10:43 EDT
Referring Person: Redacted **Referring Person's Title:** PTC
Arrival Date-Time: --/--/---- --:-- **Attending Physician:** ---------

Last Name: Organ **First:** Releaseone **Middle:** --
SSN: 789-45-6123
Address: ---------
DOB: 02/20/1980 **Age:** 40 Years **Gender:** Male
Height: --------- **Weight:** --------- **BMI:** --
Race: White: Not Specified/Unknown
Additional Race(s): ---------
Citizenship: --
U.S. Born: -- **How Long lived in U.S.:** -- **years** **Active Military:** --
Occupation: ---------
Comments:

HLA Lab: ---------

A:	--	--	**B:**	--	--	**BW4:**	--	**BW6:**	--	**C:**	--	--
DR:	--	--	**DR51:**	--	--	**DR52:**	--	--				
DR53:	--	--										
DQB1:	--	--	**DQA1:**	---------	---------	**DPB1:**	---------	---------				

Is there time for a preliminary crossmatch? --

ABO: --------- **RH:** ---------
ABO Verification Sources: ---------

Brain Death Declaration: **Was the patient declared legally brain dead:** --
BD1 Date-Time: --/--/---- --:-- **Name:** --------- --
BD2 Date-Time: --/--/---- --:-- **Name:** --------- --

DONOR INFORMATION

Methods Used: ---------
If Other, Specify: ---------
Cardiac arrest since neurological event that led to declaration of brain death? --
Asystole Date-Time: --/--/---- --:--

M.E./Coroner Case: -- **Case #:** --------- **Contact Phone:** ---------
M.E./Coroner/Hospital Name: --------- **Contacted Date-Time:** --/--/---- --:--
Autopsy: --------- **By whom:** ---------
Permission for Donation: --
Restrictions / Denial reason(s):

M.E./Other Special Requests:

UNOS Cause of Death: Anoxia **If Other, Specify:** ---------
Mechanism of Death: --------- **Circumstances of Death:** ---------
Does donor meet DCD criteria? -- **Does donor meet ECD criteria?** -- **Match KDPI:** -- % **Terminal KDPI:** -- %
Does donor meet double kidney allocation criteria? --
Use double kidney allocation instead of expanded donor allocation? --

Abdominal Allocation Start: --/--/---- --:-- **Abdominal Allocation Finish:** --/--/---- --:--
Thoracic Allocation Start: --/--/---- --:-- **Thoracic Allocation Finish:** --/--/---- --:--

Planned OR Date-Time: --/--/---- --:-- **Date-Time Reason:** ---------
Last Updated By: Redacted on 04/13/2020 17:49
Previous Planned OR Date-Time: 04/06/2020 21:00 EDT **OR Date-Time Reason:** ---------
Trx Ctr Comments:

AUTHORIZATION INFORMATION

Did the patient express to family or others the intent to be a donor? ---------
Authorization by Donor Designation: ---------

Formal Request By: --------- **Date-Time:** --/--/---- --:--

Religion: ------

Authorized Party First Name: --------- **Last Name:** ---------
Relationship: --------- **Phone:** ---------
Address: ---------

Funeral Home: --------- **Telephone #:** ---------
Name of Contact: --------- **Date-Time:** --/--/---- --:--

Restrictions/Comments:

Funeral Home Special Instructions:

ORGAN AUTHORIZATION

Organ	Authorization Requested	If not, reason	Authorization Obtained	If not, reason
Right Kidney	--		-----	
Left Kidney	--		-----	
Liver	--		-----	
Intestine	--		-----	
Pancreas	--		-----	
Heart	--		-----	
Right Lung	--		-----	
Left Lung	--		-----	
Other:	--		-----	
Other 2:	--		-----	
Other 3:	--		-----	
Other 4:	--		-----	
Other 5:	--		-----	

RESEARCH & EDUCATION AUTHORIZATION FOR TISSUES AND ORGANS

Type	Authorization Requested	If not, reason	Authorization Obtained	If not, reason
Research	--		-----	
Education	--		-----	

TISSUE AUTHORIZATION

Tissue	Authorization Requested	If not, reason	Authorization Obtained	If not, reason
Eyes - includes corneas and/or whole globes	---------		-----	
Heart for valves, blood vessels & pericardium	---------		-----	
Sternum with costal cartilage/ribs	---------		-----	
Veins & arteries	---------		-----	

AUTHORIZATION INFORMATION

Bones of the lower limbs, including hemipelvis, iliac crest, femur, tibia/fibula, talus, calcaneous and connective tissue including tendons, ligaments, nerves and fascia	---------		-----	
Skin - split and full thickness grafts	---------		-----	
Humerus, including the bone of the upper limb and connective tissue including tendons, ligaments, nerves and fascia	---------		-----	
Radius/ulna, including bones of the upper limbs and connective tissue including tendons, ligaments, nerves and fascia	---------		-----	
Other:	---------		-----	
Other 2:	---------		-----	
Other 3:	---------		-----	
Other 4:	---------		-----	

ADMISSION COURSE

Course of Events:

Radiological Studies Performed: ---------

OR Procedures: ---------

Defibrillation: --

CPR Administered: --

Cardiac Arrest/Downtime: --

Patient Name: Releaseone Organ **UNOS #:** --------
ABO: --------- **OPO #:**
MRN: 654321

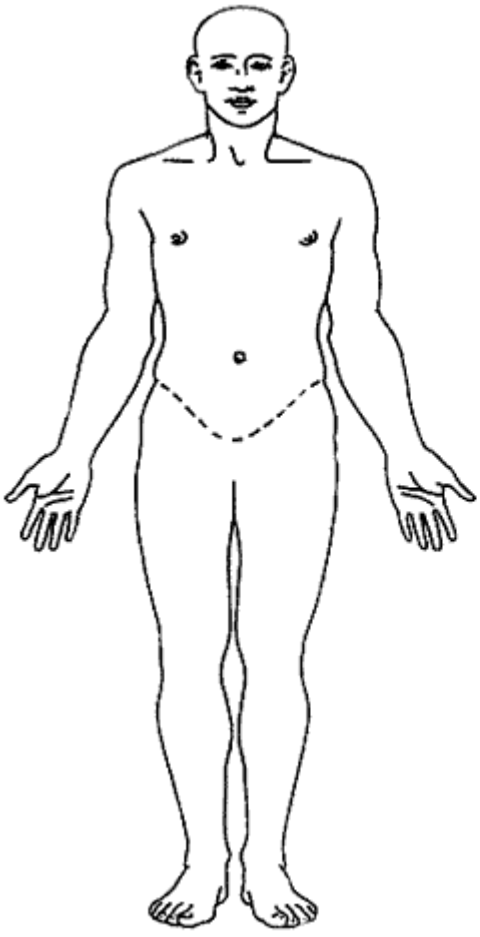
ORGAN PHYSICAL ASSESSMENT

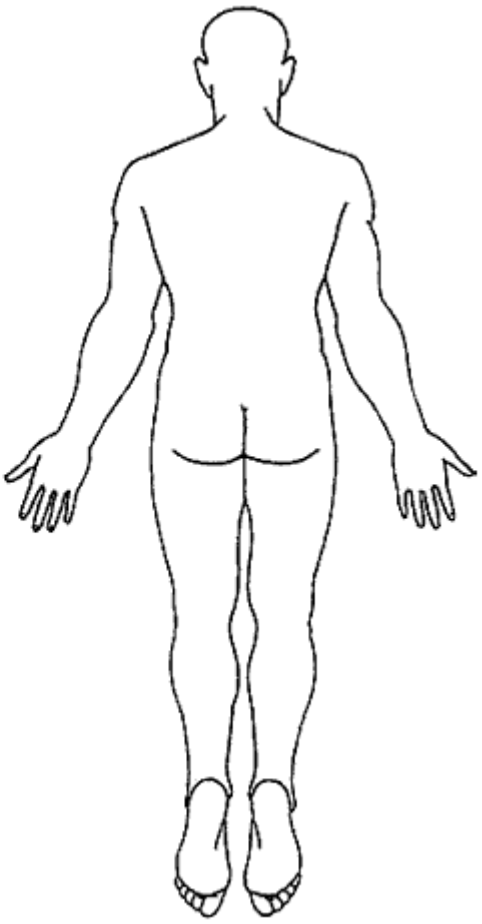
Body Identified By

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: ☐
2. Trach: ☐
3. Chest Tube: ☐
4. NG/OG/Feeding Tube: ---------

ORGAN PHYSICAL ASSESSMENT

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

Comments:

ORGAN PHYSICAL EXAMINATION

Evidence of:	**Trauma to tissue retrieval sites:**	--	**Jaundice:**	--
	Non-medical injection of drugs:	--	**Enlarged lymph nodes:**	--
	Infection:	--	**Anal tears/perianal warts:**	--
	Genital lesions:	--	**White spots in mouth:**	--
	Blue/purple spots:	--	**Unable to Visualize Oral Cavity (see comments)**	☐

PULMONARY

Tubes: **Cricothyrotomy:** ☐

Decompression: **Left Chest:** ☐ **Right Chest:** ☐

Breath Sounds: ---------

Wheezes: ☐
Clear: ☐
Rales: ☐
Rhonchi: ☐
Absent: ☐
Decreased: ☐

CARDIOVASCULAR

Lines: **Other:** ☐

Heart Rhythm: ---------

Heart Tones: ---------

Periph. Pulses: ---------

Periph. Edema: ---------

Thoracic Evaluation: **Unremarkable:** ☐ **Chest trauma:** ☐ **Intracardiac injections:** ☐ **Other:** ☐

INTEGUMENTARY

Color: --

Temperature: -- **Temp:** -- --

GASTROINTESTINAL

DPL: --

Abdomen: **Incisions:** ☐ **Surgical scars:** ☐ **Other scars:** ☐

Abdomen Texture: --

Bowel Sounds: --

Abdomen Distended: ---------

GENITOURINARY

Urine Volume: --------- **Urine Appearance:** ---------

MUSCULOSKELETAL

Fractures: ---------

COMMENTS

Comments

LAB PROFILE - CHEMISTRY

Date	--/--/----
Time	--:--
OPO/Hospital	---------
Na+ (140-160)	---------
K+ (3.5-5.5)	---------
Cl- (96-115)	---------
CO_2	---------
BUN (<20)	---------
Creatinine (<1.5)	---------
Creatinine Clearance	---------
Glucose (65-150)	---------
Calcium (8.5-10.5)	---------
Ionized Calcium	---------
Mg	---------
Phosphorus	---------
Lactate	---------
Total Bili	---------
Direct/Conjugated Bili	---------
Indirect/Unconj. Bili	---------
SGOT (AST) (0-40)	---------
SGPT (ALT) (5-35)	---------
Alk Phos	---------
GGT (17-55)	---------
Albumin	---------
Total Protein	---------
LDH	---------
PT (11-15)	---------
INR	---------
PTT (24-36)	---------
CK/MB	---------
CPK	---------
CPK Index (<2.5%)	---------
Total MB	---------
Troponin-I	---------
Troponin-T	---------
Amylase	---------
Lipase (0-80)	---------
Lipase ULN	---------
Hgb A1C (2%-15%)	---------
BNP	---------
Serum Osmo	----------
Serum Beta HCG	---------
Fibrinogen	---------
---------	---------
---------	---------
---------	---------

LAB PROFILE - CHEMISTRY

---------	---------
---------	---------

Comments:

LAB PROFILE - CBC

Date-Time	--/--/---- --:--
OPO/Hospital	---------
WBC	---------
RBC	---------
Hgb	---------
Hct	---------
Platelets	---------
Segs	---------
Lymphs	---------
Bands	---------
Mono	---------
Eos	---------
---------	---------
---------	---------

Comments:

LAB PROFILE - TOXICOLOGY

Serum Alcohol: ---------

Urine Toxicology: ---------

Comments:

CULTURE RESULTS

☐ **Cultures Not Done**

DDR CLINICAL INFECTIONS

Clinical Infection Confirmed by Culture: ---------

CULTURE RESULTS

Source:	N/A	**Date-Time:**	--/--/---- --:--
24 hr Result:	---------		
48 hr Result:	---------		
Final Result:	---------		
Sensitivities:	---------		
DonorNet Result:	---------		

Patient Name: Releaseone Organ
ABO: ---------

UNOS #: ---------
OPO #:
MRN: 654321

CULTURE/SAFETY REPORT

Organ/ Tissue	Date-Time Received	Result Type, Source	Date-Time Reported	Staff Reporting	Method, Ph#/ Fax#/ Email	Reported To - Name, Title	TxC/OPO	Posi-tive?	Change from prior results?	Clinical Reviewer
------	--/--/---- --:--	--------- ---------	--/--/---- --:--	---------	---------: ---------	---------, ---------	---------	-------- -	---------	---------

Comments:

HEMODYNAMICS/TEMPERATURE

From: Date-Time	--/--/---- --:--
To: Date-Time	--/--/---- --:--
Average BP	-- / --
Heart Rate	-- - --
High BP	-- / --
Duration	-- --
Low BP	-- / --
Duration	-- --
Heart Rhythm	---------
Hourly Urine Output	-- - --
CVP	-- - --
PA	-- / -- - -- / --
PAWP	--
PAMP	-- - --
PCWP	-- - --
CO/CI	-- / -- - -- / --
SVV	--
SVI	--
Temp	-- - -- ℃
Warming Device	---------
Cooling Device	---------
Drug	---------
Dosage	---------
Unit	---------
Drug	---------
Dosage	---------
Unit	---------
Drug	---------
Dosage	---------
Unit	---------
Drug	---------
Dosage	---------
Unit	---------
Drug	---------
Dosage	---------
Unit	---------

Vital Signs Comments:

Patient Name:	Releaseone Organ	**UNOS #:**	---------	
ABO:	**---------**	**OPO #:**		
		MRN:	654321	

FLOWSHEET

Date-Time	04/05/2020 15:00	04/06/2020 07:59	04/06/2020 08:00	04/06/2020 09:00
VITAL SIGNS				
BP	--/--	--/--	--/--	--/--
MAP	---------	---------	---------	---------
HR	--	--	--	--
Temperature	-- °C	-- °C	-- °C	-- °C
Temperature Regulating Device	---------	---------	---------	---------
CVP	---------	---------	---------	---------
PA	--/--	--/--	--/--	--/--
PCWP	--	--	--	--
PAMP	--	--	--	--
CO/CI	--/--	--/--	--/--	--/--
SaO2%	---------	---------	---------	---------
SVR	--	--	--	--
PVR	--	--	--	--
SVRI	--	--	--	--
SVV	--	--	--	--
PPV	--	--	--	--
RVSWI	--	--	--	--
LVSWI	--	--	--	--
Glucose checks	---------	---------	---------	---------
---------	---------	---------	---------	---------
---------	---------	---------	---------	---------
---------	---------	---------	---------	---------
---------	---------	---------	---------	---------
VENT SETTINGS	04/05/2020 15:00	04/06/2020 07:59	04/06/2020 08:00	04/06/2020 09:00
Mode	---------	---------	---------	---------
Rate	---------	---------	---------	---------
FiO2	---------	---------	---------	---------
TV	---------	---------	---------	---------
Peep	---------	---------	---------	---------
PC	---------	---------	---------	---------
PIP	---------	---------	---------	---------
---------	---------	---------	---------	---------
---------	---------	---------	---------	---------
---------	---------	---------	---------	---------
INTAKE	04/05/2020 15:00	04/06/2020 07:59	04/06/2020 08:00	04/06/2020 09:00
Fluid / Additive	Dosage/Vol(mls)/Unit	Dosage/Vol(mls)/Unit	Dosage/Vol(mls)/Unit	Dosage/Vol(mls)/Unit
NS/---------	--/--/---------	--/--/---------	--/100/ml/hr	--/100/---------
t/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
---------/---------	--/--/---------	--/--/---------	--/--/---------	--/--/---------
Medications	Dosage/Vol(mls)/Unit	Dosage/Vol(mls)/Unit	Dosage/Vol(mls)/Unit	Dosage/Vol(mls)/Unit
---------	--/--/--	--/--/--	--/--/--	--/--/--
---------	--/--/--	--/--/--	--/--/--	--/--/--
---------	--/--/--	--/--/--	--/--/--	--/--/--

FLOWSHEET

---------	--/--/--	--/--/--	--/--/--	--/--/--
---------	--/--/--	--/--/--	--/--/--	--/--/--
Intake Total	---------	---------	100	100
OUTPUT	04/05/2020 15:00	04/06/2020 07:59	04/06/2020 08:00	04/06/2020 09:00
Urine Output (ml/hr)	100	2000	0	0
CHHV	--	--	100	150
---------	--	--	--	--
Output Total	--	2000	100	150
Running Balance	--	-2000	-2000	-2050
Exclude Intake Total/Output Total /Running Balance	☑	☐	☐	☐

Comments:

MEDICATIONS/OTHER DRUGS

DONORNET INOTROPIC MEDICATIONS

Begin Date-Time	End Date-Time	Inotropic Medication	Value	Units	Duration
--/--/---- --:--	--/--/---- --:--	---------	---------	---------	---------

MEDICATIONS/OTHER DRUGS

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

Comments:

FLUID BALANCE

FLUID INTAKE					FLUID/URINE OUTPUT			
Start Date-Time / End Date-Time	Crystalloid ml.	Colloid ml.	Blood Products ml.	Total Fluid Intake ml. / Hour Average	Total Urine Output ml. / Hour Average	Output ml. / Non-Urine Output Type	Total Output ml.	Lowest Urine Output ml. / Hour Duration
--/--/---- --:-- / --/--/---- --:--	--	--	--	------ / ------	-- / ------	-- / ---------	------	-- / --
Intake Total				0 ml / 0 ml/hr	Output Total		0 ml	

COMMENTS

BLOOD PRODUCT/COLLOID ADMINISTRATION SUMMARY

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

Comments:

Patient Name: Releaseone Organ **UNOS #:** ---------
ABO: **---------** **OPO #:**
MRN: 654321

TRANSFUSION/INFUSION - HEMODILUTION WORKSHEET

Date-Time sample drawn: --/--/---- --:--

Transfusion of blood products within 48 hrs prior to specimen draw or asystole			Infusion of colloids within 48 hrs prior to specimen draw or asystole		
Date-Time	**Blood Type**	**Volume**	**Date-Time**	**Colloid Type**	**Volume**
--/--/---- --:--	---------	--	--/--/---- --:--	---------	--

Donor weight in kilograms: --

ESTIMATED TOTAL PLASMA VOLUME (TPV)

TPV = Donor Wt (kg) -- / 0.025
TPV = -- **mls**

ESTIMATED TOTAL BLOOD VOLUME (TBV)

TBV = Donor Wt (kg) -- / 0.015
TBV = -- **mls**

A: TOTAL VOLUME OF BLOOD TRANSFUSED IN THE LAST 48 HOURS

RBC's (packed cells) =	-- **mls**
Whole Blood =	-- **mls**
Other Blood Products =	-- **mls**
Total of A =	0.0 **mls**

B: TOTAL VOLUME OF COLLOIDS INFUSED IN THE LAST 48 HOURS

FFP/Plasma =	-- **mls**
Platelets =	-- **mls**
Cryoprecipitate =	-- **mls**
Albumin 5% =	-- **mls**
Albumin 25% =	-- **mls**
Dextran =	-- **mls**
Other Colloids =	-- **mls**
Total of B =	0.0 **mls**

C: TOTAL VOLUME OF CRYSTALLOIDS INFUSED IN LAST HOUR

Date-Time	Type	Volume	
--/--/---- --:--	---------	--	**mls**

Total of C = 0.0 **mls**

D: DETERMINATION OF ELIGIBILITY

1) Is B + C < TPV?	(	0.0	+	0.0	=	0.0	)	**<**	--	**?**	N/A
2) Is A + B + C < TBV?	(	0.0	+	0.0	+	0.0	=	0.0	)	**<**	--	**?**	N/A

Weight and Date-Time Sample Drawn must have values to calculate Determination of Eligibility

Comments:

SEROLOGIES

Date-Time Drawn: --/--/---- --:-- **Identifier:** ---------
Serology Lab: --------- **Date-Time Results Obtained:** --/--/---- --:--
Pre-transfusion or Post-transfusion: not selected **Qualified:** --

Serology ABO: --

For UNET*		Result
☑	**Anti-HBc:**	---------
☑	**Anti-HCV:**	---------
☑	**Anti-HIV I/II:**	---------
☑	**Anti-HTLV I/II:**	---------
☑	**HBsAg:**	---------
☑	**Anti-CMV:**	---------
☑	**Syphilis:**	---------
☑	**HBsAb:**	---------
☑	**EBV (VCA) (IgG):**	---------
☑	**EBV (VCA) (IgM):**	---------
☑	**EBNA:**	---------
☑	**Chagas:**	---------
	CMV IgM:	---------
	HBcAB IgM:	---------
☑	**HIV NAT:**	---------
☑	**HCV NAT:**	---------
☑	**HBV NAT:**	---------
☑	**Toxo Ab IgG:**	---------
	Toxo Ab IgM:	---------
☑	**WNV:**	---------
☑	**WNV NAT:**	---------
☑	**HIV Ag/Ab Combo:**	---------
☑	**HTLV NAT:**	---------
☑	**Chagas NAT:**	---------
☑	**Strongyloides:**	---------
	---------:	---------
	---------:	---------

***Note: UNET upload only includes test results for tests that are available in UNET at time of upload.**

Comments:

EKG

Not Performed: ☐

Result:	---------	**Date-Time:**	--/--/---- --:--
Consulting Physician:	---------		
Rhythm:	---------	**Heart Rate:**	-- **BPM**
Interpretation:			

Patient Name: Releaseone Organ
ABO: ---------

UNOS #: ---------
OPO #:
MRN: 654321

ECHOCARDIOGRAM

Type: ---------
Date-Time: --/--/---- --:--
Consulting Physician: ---------
Interpretation:

CVP:	--	**EF:**	--	**BP:**	-- / --	**HR:**	--	**Cardiac Rhythm:**	--
CO:	--	**CI:**	--	**PAWP:**	--	**SF:**	--	**PA Pressure:**	--

PRESSORS

Pressors: --

MEASUREMENTS

Estimated LV Ejection Fraction:	-- %
LV End Systolic Dimension LVIDS:	-- --
LV End Diastolic Dimension LVIDd:	-- --
Vent. Septal Wall Thickness IVSd:	-- --
LV Posterior Wall Thickness LVPWd:	-- --

Comments:

ANGIOGRAPHY

Not Performed: ☐

Type of Cardiac Catheterization: ---------
Volume Of Dye: ---------
Date-Time: --/--/---- --:-- **Consulting Physician:** ---------
Interpretation: ---------

CXR

Chest X-ray:	---------			**Note:**	**This value will be uploaded to DonorNet.**
Date-Time:	--/--/---- --:--	**Result:**	---------	**MD:**	---------

Interpretation:

BRONCHOSCOPY

Not Performed: ☐

Date-Time: --/--/---- --:-- **Consulting Physician:** ---------

Interpretation:

Bronchial washings sent for culture/gram stain? --------- **If performed, see culture page for results**

LUNG MEASUREMENT

Not Performed: ☐

Chest X-ray utilized for measurement:	--/--/---- --:--		
Length of Right Lung:	-- cms	**Length of Left Lung:**	-- cms
Aortic Knob Width:	-- cms	**Diaphragm width:**	-- cms
Chest Circ./Landmark:	-- cms	**Dist. RCPA to LCPA:**	-- cms

Age:	40 Years	**Gender:**	Male	**Height:**	---------
Total Lung Capacity:	Not Enough Information	**Vital Capacity:**	Not Enough Information		

Additional Comments: ---------

ARTERIAL BLOOD GASES

Date-Time	pH	pCO2	pO2	BE	HCO3	O_2Sat	FiO_2	Rate	TV	PEEP	PiP	Mode
--/--/---- --:--	--	--	--	--	--	--	--	--	--	--	--	--
OPO/Hospital:	---------											
Comments:	---------											

DIAGNOSTIC TESTS

Type: ---------
Date-Time: --/--/---- --:--
Diagnostic evaluation/results:

INTRAOPERATIVE MANAGEMENT

HOSPITAL INFORMATION

Is this a DCD Recovery?	Yes				
Lifebanc Recovery Center?	Yes	**If yes, location:**	--		
Enter OR Date-Time:	--/--/---- --:--				
Incision Date-Time:	--/--/---- --:--				
Crossclamp Date-Time:	--/--/---- --:--				
Exit OR Date-Time:	--/--/---- --:--				
Avg BP:	--/--				
Low BP:	--/--	**Duration:**	---------	**Duration Type:**	--
High BP:	--/--	**Duration:**	---------	**Duration Type:**	--
Avg HR:	--				
Low HR:	--	**Duration:**	---------	**Duration Type:**	--
High HR:	--	**Duration:**	---------	**Duration Type:**	--
Avg SpO2:	--				
Low SpO2:	--	**Duration:**	---------	**Duration Type:**	--
High SpO2:	--	**Duration:**	---------	**Duration Type:**	--

Last hour urine output: -- ml **Total urine output in OR:** -- ml **Average urine:** --

Any Extracorporeal Support Given (ECMO, etc.): --

MEDICATIONS

Heparin:	☐
Mannitol:	☐
Lasix:	☐
Solumedrol:	☐
T4:	☐
Thorazine:	☐
TPA:	☐
Other Medication 1:	☐
Other Medication 2:	☐
Other Medication 3:	☐
Other Medication 4:	☐
Vasodilators:	☐
Pressors:	☐
Blood products 1:	☐
Blood products 2:	☐
Crystalloids:	☐

Comments:

OR TEAMS

HEART	HEART / LUNG	RIGHT LUNG	LEFT LUNG
Recovering Surgeon:	**Recovering Surgeon:**	**Recovering Surgeon:**	**Recovering Surgeon:**
-- --	-- --	-- --	-- --
Assistant Surgeon:	**Assistant Surgeon:**	**Assistant Surgeon:**	**Assistant Surgeon:**
-- --	-- --	-- --	-- --
Other Team Members:	**Other Team Members:**	**Other Team Members:**	**Other Team Members:**
-- --	-- --	-- --	-- --
-- --	-- --	-- --	-- --

LIVER	KIDNEY	PANCREAS	INTESTINE
Recovering Surgeon:	**Recovering Surgeon:**	**Recovering Surgeon:**	**Recovering Surgeon:**
-- --	-- --	-- --	-- --
Assistant Surgeon:	**Assistant Surgeon:**	**Assistant Surgeon:**	**Assistant Surgeon:**
-- --	-- --	-- --	-- --
Other Team Members:	**Other Team Members:**	**Other Team Members:**	**Other Team Members:**
-- --	-- --	-- --	-- --

ANESTHESIA	CIRCULATOR	SCRUBS	OTHERS
Anesthesia 1:	**Circulator 1:**	**Scrubs 1:**	**Others 1:**
-- --	-- --	-- --	-- --
Anesthesia 1 Title:	**Circulator 1 Title:**	**Scrubs 1 Title:**	**Others 1 Title:**
---	---	---	---
Anesthesia 2:	**Circulator 2:**	**Scrubs 2:**	**Others 2:**
-- --	-- --	-- --	-- --
Anesthesia 2 Title:	**Circulator 2 Title:**	**Scrubs 2 Title:**	**Others 2 Title:**
---	---	---	---
Anesthesia 3:	**Circulator 3:**	**Scrubs 3:**	**Others 3:**
-- --	-- --	-- --	-- --
Anesthesia 3 Title:	**Circulator 3 Title:**	**Scrubs 3 Title:**	**Others 3 Title:**
---	---	---	---

OPO STAFF 1	OPO STAFF 2	OPO STAFF 3	OPO STAFF 4
---	---	---	---

Anesthesia requirements given to: --- **Date-Time Given:** --/--/---- --:--

Abdominal and chest cavities visually inspected for contraindications to donation by: ---

Comments:

Patient Name: Releaseone Organ
ABO: ---------

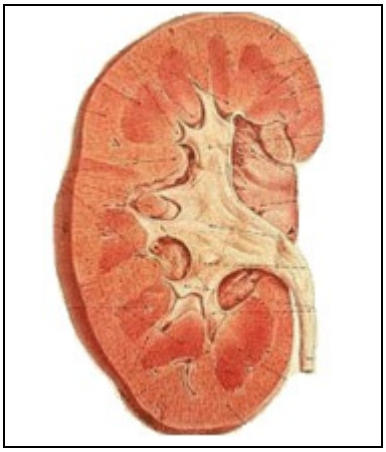
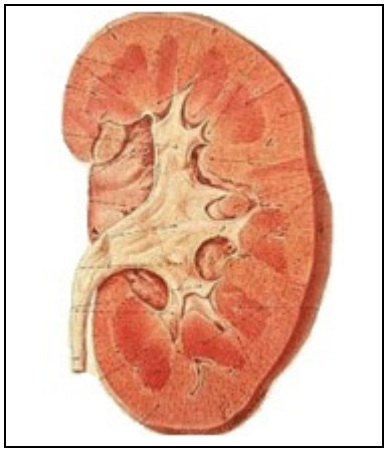
UNOS #: ---------
OPO #:
MRN: 654321

RENAL DATA

XClamp Date-Time: --/--/---- --:--
Warm Ischemic Time: ---------
Initial Flush (Insitu): --
Backtable Flush: --
Storage Solution: ---------
Volume: --------- ml
Storage Solution Additives: ---------
Typing materials:
Nodes: ☐ **Spleen:** ☐ **Blood Clot:** ☐ **Other:** ☐
Right kidney pump device: ---------
Left kidney pump device: ---------
Right kidney pump solution: ---------
Left kidney pump solution: ---------
Right kidney pump solution additives: ---------
Left kidney pump solution additives: ---------
Right kidney transferred to transplant center on pump: --
Left kidney transferred to transplant center on pump: --

Recovering Surgeon: ---------
Assistant Surgeon: ---------
Recovery Program: ---------
Sent en bloc: --

Match KDPI: -- %
Terminal KDPI: -- %
Comments:

RIGHT KIDNEY	RIGHT		RENAL ANATOMY		LEFT	LEFT KIDNEY
	--		Aortic Plaque		--	
	--		Arterial Plaque		--	
	--	1	Infarcted area(s)	1	--	
	--	2	Capsule Tear	2	--	
	--	3	Subcapsular hematoma(s)	3	--	
	--	4	Cysts/Discoloration	4	--	
	--		Fat cleaned		--	
	--		Pumped		--	
	--	5	Biopsy	5	--	
	Biopsy Type: ---------				**Biopsy Type:** ---------	

RIGHT KIDNEY ANATOMY

Kidney Recovered? --
Date-Time Recovered: --/--/---- --:--
Kidney Size
Length: -- cm **Width:** -- cm **Depth:** -- cm
Arteries #: -- **Distance apart:** -- --
Distance apart: -- --
Aortic Cuff: --
Right Kidney Arteries On a Common Cuff? --

Length:	-- cm	-- cm	-- cm
Diameter:	-- mm	-- mm	-- mm

Comments:

LEFT KIDNEY ANATOMY

Kidney Recovered? --
Date-Time Recovered: --/--/---- --:--
Kidney Size
Length: -- cm **Width:** -- cm **Depth:** -- cm
Arteries #: -- **Distance apart:** -- --
Distance apart: -- --
Aortic Cuff: --
Left Kidney Arteries On a Common Cuff? --

Length:	-- cm	-- cm	-- cm
Diameter:	-- mm	-- mm	-- mm

Comments:

RENAL DATA

Veins #: -- **Distance apart:** -- --	**Veins #:** -- **Distance apart:** -- --
Distance apart: --------- --	**Distance apart:** --------- --
Full Vena Cava: --	**Full Vena Cava:** -- **Cuff of Cava:** --
Length: -- cm **Width:** -- cm **Depth:** -- cm	**Length:** -- cm **Width:** -- cm **Depth:** -- cm
Diameter: -- mm **Width:** -- mm **Depth:** -- mm	**Diameter:** -- mm **Width:** -- mm **Depth:** -- mm
Comments: ---	**Comments:** ---
Ureter: ---	**Ureter:** --
Length: -- cm -- cm -- cm	**Length:** -- cm -- cm -- cm
Comments: ---	**Comments:** ---
Abnormalities: --	**Abnormalities:** --
Surgical Damage: --	**Surgical Damage:** --
Additional Surgeon Comments:	**Additional Surgeon Comments:** ---
Pump requested by: ---	**Pump requested by:** ---
Reason: ---	**Reason:** ---
Laterality Marked? --	**Laterality Marked?** --

RIGHT KIDNEY BIOPSY INFORMATION	LEFT KIDNEY BIOPSY INFORMATION
Glomeruli Seen: -- **Glomeruli Sclerosed:** --	**Glomeruli Seen:** -- **Glomeruli Sclerosed:** --
Glomeruli Sclerosis: --	**Glomeruli Sclerosis:** --
Kidney Interstitial Fibrosis: ---	**Kidney Interstitial Fibrosis:** ---
Kidney Inflammation: ---	**Kidney Inflammation:** ---
Comments: ---	**Comments:** ---
Kidney Arterial Sclerosis: --	**Kidney Arterial Sclerosis:** --
Kidney Vascular Changes: ---	**Kidney Vascular Changes:** ---
Comments: ---	**Comments:** ---
Other Pathology or Anatomic Abnormalities: ---	**Other Pathology or Anatomic Abnormalities:** ---
Kidney Pathologist Name: ---	**Kidney Pathologist Name:** ---
Phone Number: ---	**Phone Number:** ---
Date-Time Results Reported: --/--/---- --:--	**Date-Time Results Reported:** --/--/---- --:--

COMMENTS

Patient Name: Releaseone Organ **UNOS #:** ---------
ABO: --------- **OPO #:**
MRN: 654321

LIVER DATA

Liver Recovered? --
Warm Ischemic Time: ---------
Initial Flush Solution: ---------

☐	Aortic Flush	**Start Time:** --:--	**Volume:**	--------- **ml**	**Char:** --
☐	Portal Flush	**Start Time:** --:--	**Volume:**	--------- **ml**	**Char:** --

Flush Additives: ---------
Backtable Flush Solution: ---------

☐	Aortic Flush	**Start Time:** --:--	**Volume:**	--------- **ml**	**Char:** --
☐	Portal Flush	**Start Time:** --:--	**Volume:**	--------- **ml**	**Char:** --

Backtable Flush Additives: ---------
Storage Solution: --------- **Volume:** --------- **ml**
Storage Solution Additives: ---------
Typing materials:
Nodes: ☐ **Spleen:** ☐ **Blood Clot:** ☐ **Other:** ☐
Liver Machine Perfusion: --
Vessels Sent: --
Anatomical Abnormality: --
Surgical Damage: No
Capsule Torn: --
Hematoma: --
Gall Bladder Incised: --
Gall Bladder Flushed: --
Replaced Left Hepatic: --
Replaced Right Hepatic: --
Biopsy: --
Recovering Surgeon: --------- **Assistant Surgeon:** ---------
Recovery Program: ---------
Comments:

Patient Name: Releaseone Organ
ABO: ---------

UNOS #: ---------
OPO #:
MRN: 654321

HEART DATA

Heart Recovered? --

Initial Flush: --------- **Volume:** --------- ml **Char:** --
Flush Additives: ---------
Backtable Flush Solution: --------- **Volume:** --------- ml
Backtable Flush Additives: ---------
Storage Solution: --------- **Volume:** --------- ml
Storage Solution Additives: ---------
Typing materials:
Nodes: ☐ **Spleen:** ☐ **Blood Clot:** ☐ **Other:** ☐
Heart Machine Perfusion: --
Anatomical Abnormality: --
Surgical Damage: --
Evidence/CV Disease: --

Recovering Surgeon: --------- **Assistant Surgeon:** ---------
Recovery Program: ---------
Comments:

LUNG DATA

Initial Flush: --------- **Volume:** --------- **ml** **Char:** ---------
Flush Additives: ---------
Backtable Flush: ---------
Storage Solution: --------- **Volume:** --------- **ml**
Storage Solution Additives: ---------
Typing materials:
Nodes: ☐ **Spleen:** ☐ **Blood Clot:** ☐ **Other:** ☐

RIGHT LUNG

Right Lung Recovered? ---------
Anatomical Abnormality: --
Surgical Damage: --
Recovering Surgeon: --------- **Recovery Program:** ---------
Right Lung Perfusion Machine Intended or Performed: --
Comments:

LEFT LUNG

Left Lung Recovered? ---------
Anatomical Abnormality: --
Surgical Damage: --
Recovering Surgeon: --------- **Recovery Program:** ---------
Left Lung Perfusion Machine Intended or Performed: --
Comments:

PANCREAS DATA

Pancreas Recovered? --
Warm Ischemic Time: ---------
Initial Flush (Aortic): **Start Time:** --:-- **Solution:** --------- **Volume:** --------- **Char:** --
Flush Additives: ---------
Backtable Flush (Splenic): --
SMA Flush (backtable): --
Storage Solution: --------- **Volume:** ---------
Storage Solution Additives: ---------
Typing materials:
Nodes: ☐ **Spleen:** ☐ **Blood Clot:** ☐ **Other:** ☐
Whole: -- **Celiac:** -- **Spleen Attached:** -- **Portal Vein:** --
Vessels Sent: -- **Comments:** ---------
Anatomical Abnormality: -- **Comments:** ---------
Surgical Damage: -- **Comments:** ---------
Bowel prep: ---------

Recovering Surgeon: --------- **Assistant Surgeon:** ---------
Recovery Program: ---------
Comments:

INTESTINE DATA

Intestine Recovered? --
Initial Flush: --------- **Volume:** --------- **Char:** --
Flush Additives: ---------
Backtable Flush: --
Storage Solution: --------- **Volume:** ---------
Storage Solution Additives: ---------
Typing materials:
Nodes: ☐ **Spleen:** ☐ **Blood Clot:** ☐ **Other:** ☐
Vessels Sent: -- **Comments:** ---------
Anatomical Abnormality: -- **Comments:** ---------
Surgical Damage: -- **Comments:** ---------
Bowel Prep: --
Recovering Surgeon: ---------
Assistant Surgeon: ---------
Recovery Program: ---------
Comments:

Patient Name: Releaseone Organ
ABO: ---------

UNOS #: ---------
OPO #:
MRN: 654321

HOSPITAL PERSONNEL FORM

ICU STAFF

MD #1: (Sal., First, Last)

MD #2: (Sal., First, Last)

Nurse #1: (Sal., First, Last)

Nurse #2: (Sal., First, Last)

Nurse #3: (Sal., First, Last)

Nurse #4: (Sal., First, Last)

Other #1: (Sal., First, Last)

Other #2: (Sal., First, Last)

Other #3: (Sal., First, Last)

Other #1 Role: ---------

Other #2 Role: ---------

Other #3 Role: ---------

Other #4: (Sal., First, Last)

Other #5: (Sal., First, Last)

Other #6: (Sal., First, Last)

Other #4 Role: ---------

Other #5 Role: ---------

Other #6 Role: ---------

PHYSICIANS

Attending: ---------

Declaring #1: ---------

Declaring #2: ---------

CONSULTS

Cardiac: (Sal., First, Last)

Pulmonary: (Sal., First, Last)

Pathologist: (Sal., First, Last)

Other MD #1: (Sal., First, Last)

Other MD #2: (Sal., First, Last)

Other MD #3: (Sal., First, Last)

Other MD #4: (Sal., First, Last)

Other MD #5: (Sal., First, Last)

Other MD #6: (Sal., First, Last)

OR STAFF

Anesthesia: (Sal., First, Last)

CRNA: (Sal., First, Last)

Scrub: (Sal., First, Last)

Circulation: (Sal., First, Last)

Other #1: (Sal., First, Last)

Other #2: (Sal., First, Last)

Other #1 Role: ---------

Other #2 Role: ---------

Other #3: (Sal., First, Last)

Other #4: (Sal., First, Last)

Other #5: (Sal., First, Last)

Other #3 Role: ---------

Other #4 Role: ---------

Other #5 Role: ---------

ER STAFF

ER Staff #1: (Sal., First, Last)

ER Staff #2: (Sal., First, Last)

ER Staff #3: (Sal., First, Last)

OTHER

Chaplain: (Sal., First, Last)

Coroner: (Sal., First, Last)

Family Support Coordinator: (Sal., First, Last)

Other #1: (Sal., First, Last)

Other #2: (Sal., First, Last)

Other #3: (Sal., First, Last)

Other #1 Role: ---------

Other #2 Role: ---------

Other #3 Role: ---------

CORE Redacted

FINAL COPY

Donor: N/A, N/A Acc #: 110724

SAMPLE SEROLOGIES

ABO/Rh		Redacted Redacted
ABO	A	
A1 Lectin	Positive	
Rh	Negative (-)	
Notes: ABO/Rh confirmed by 2nd technician		
Hepatitis B Core Total Ab (IgG/IgM)		Redacted Redacted Redacted
Hep B Core Total Ab (Results)	Nonreactive	Nonreactive
Method: ELISA Kit: ORTHO® HBc ELISA		
Manufacturer: Ortho Clinical Diagnostics		
Procleix Ultrio		Redacted Redacted
Procleix Ultrio	Nonreactive	Non-Reactive
Method: Transcription-Mediated Amplification		
Kit: Procleix® Ultrio® Assay (HIV-1/HBV/HCV NAT)		
Manufacturer: Grifols Diagnostic Solutions Inc.		
Hepatitis B Surface Antigen		Redacted Redacted
Hep B Surface Antigen (Result)	Nonreactive	Nonreactive
Method: EIA Kit: GS HBsAg EIA 3.0		
Manufacturer: Bio-Rad Laboratories		
HCV Ab		Redacted Redacted Redacted
HCV Ab (Result)	Nonreactive	Nonreactive
Method: ELISA Kit: ORTHO® HCV Version 3.0 ELISA		
Manufacturer: Ortho Clinical Diagnostics		
HIV 1-2 Plus O Ab		Redacted Redacted
HIV 1-2 Plus O Ab (Result)	Nonreactive	Nonreactive
Method: EIA Kit: GS HIV-1/HIV-2 Plus O EIA		
Manufacturer: Bio-Rad Laboratories		
CMV Total Ab (IgG/IgM)		Redacted Redacted
CMV Total Ab (Results)	Negative	Negative
Method: Solid phase red cell adherence Kit: Capture-CMV®		
Manufacturer: Immucor, Inc.		
RPR		Redacted Redacted
RPR	Nonreactive	Nonreactive
Method: Nontreponemal Flocculation Kit: ASi RPR Card Test/ASiManager-AT		
Manufacturer: Arlington Scientific, Inc.		
EBV-VCA IgG Ab		Redacted Redacted

Originally Reported On: Redacted
Printed: Redacted
Page 1 of 2

STAT[S] Corrected [C] Added [A]

Accession: Redacted Donor ID: Redacted
Lab Results For: N/A N/A

CORE

Redacted

FINAL COPY

Test Name	Result	Units	Flag	Reference Range
EBV-VCA IgG Ab				Redacted Redacted Redacted
EBV-VCA IgG Ab (Result)	Positive		ABNORMAL	
Method: Indirect Chemiluminescence Immunoassay Kit: Liason® VCA IgG				
Manufacturer: DiaSorin, Inc				
EBV-VCA IgM Ab				Redacted Redacted
EBV-VCA IgM Ab (Result)	Negative			
Method: Indirect Chemiluminescence Immunoassay Kit: Liason® EBV IgM				
Manufacturer: DiaSorin, Inc				
Toxoplasma IgG Ab				Redacted Redacted Redacted
Toxoplasma IgG (Result)	Negative			
Method: Indirect Chemiluminescence Immunoassay Kit: Liason® Toxo IgG II				
Manufacturer: DiaSorin, Inc				
Toxoplasma IgM Ab				Redacted Redacted
Toxoplasma IgM (Result)	Negative			
Method: Indirect Chemiluminescence Immunoassay Kit: Liason® Toxo IgM II				
Manufacturer: DiaSorin, Inc				

Notes: *Red Lot: 8303625 Exp. Date: 11/30/2020*
EDTA Lot: 8276648 Exp. Date: 10/31/2020
EDTA Lot: 8187653 Exp. Date: 07/31/2020

All Positive/Reactive Results are Repeated per Manufacturer Insert. A minimum of 1 ml Serum & EDTA Plasma archived when available.
Effective 9-1-2015 Syphilis (RPR) Testing is performed on FDA Cleared ASIManager-AT.