

CONFIDENTIAL DONOR REFERRAL

PHONE 24HRS / DAY AND ASK FOR THE DONOR COORDINATOR ON CALL

QLD 07 3240 2111

ACT 02 6244 2222

SA 08 8378 1671

NZ +64 9 630 0935

NSW 02 9963 2801

VIC / TAS 03 9347 0408

WA 08 9346 3333

NT 08 8922 8888

NAME:

MRN:

DOB:

ID Label

DONOR HOSPITAL

DONOR NUMBER

DATE

TIME

REFERRED BY

PHONE

DONOR COORDINATOR



Donor Number	MRN	Date of Birth	
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Age: _____ DOB: _____
 Sex: Male / Female Race: _____
 ABO: _____ Subtype: _____
 Weight: _____ kg Girth: _____ cm
 Height: _____ cm Build: _____

	Name	Date	Time
Hospital 1			
Hospital 2			
Intubation			
Admitted ICU			
X - Clamp			

Cause of Death: _____

DECLARATION OF DEATH

Brain Death Cardiac Death

Doctor 1 Name: _____
 Designation: _____
 Date: / / Time: _____

Doctor 2 Name: _____
 Designation: _____
 Date: / / Time: _____

Clinical Angiography

Radionuclide

CORONERS CASE

Coroners Case: Y / N Post Mortem: Y / N

Coroner Name: _____

Consent: Y / N Date: / / Time: _____

Pathologist Name: _____

Restrictions: _____

Date: / / Time: _____

Police ID: _____

Officer Name: _____

Station: _____

Contact Number: _____

DESIGNATED OFFICER

Designated Officer Name: _____

Date: / / Time: _____ Contact Number: _____

CONSENT

Organ	Consent Requested?	If no, reason?	Consent Obtained?	If no, reason?
Heart	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Lungs	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Liver	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Kidneys	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Pancreas	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cardiovascular Tissue	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Musculoskeletal Tissue	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Eye Tissue	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Research	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

If tissue retrieved is unable to be transplanted research return to body respectfully dispose

Any Limitations? _____

Donor Number	MRN	Date of Birth	
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Significant Events / Injuries:

.....

.....

.....

.....

Cardiac Arrest: Y / N

CPR: Y / N

Duration

Type / Rhythm / Treatment

.....

.....

Temperature < 35°C Y / N °C for _____ hrs BP < 70mmHg Syst Y / N MmHg for _____ hrs

Temperature > 39°C Y / N °C for _____ hrs BP > 170mmHg Syst Y / N MmHg for _____ hrs

Oliguria Y / N < 20ml for _____ hrs

ECG / / : hrs Reported by _____ (Name)

ECHO / / : hrs Reported by _____ (Name)

CXR / / : hrs Reported by _____ (Name)

BRONCHOSCOPY / / : hrs Reported by _____ (Name)

/ / : hrs Reported by _____ (Name)

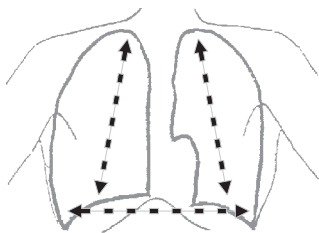
Aspiration Y / N

Tracheostomy Y / N

Chest drain Y / N

Sputum (colour / quantity / consistency)

Lung Measurements



Left lung _____ cm (Apex to base)

Right lung _____ cm (Apex to base)

Transthoracic _____ cm (Widest points)

Donor Number	MRN	Date of Birth					
Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time
HAEMODYNAMICS							
BP							
MAP							
HR							
CVP							
Temperature							
Urine Output							
GAS EXCHANGE							
PH 7.35-7.45							
PaO2 80-100							
PaCO2 35-45							
BE -3.0-3.0							
HCO3 24-32							
FiO2							
PEEP							
BIOCHEMISTRY							
Na (135-145)							
K (3.5-4.5)							
Ca (2.25-2.6)							
Urea (3.0-8.0)							
Creat (50-100)							
T Bili (<20)							
ALP (30-100)							
AST (<40)							
ALT (<35)							
GGT (<50)							
T Protein (62-83)							
Albumin (35-50)							
Glucose (3.0-7.5)							
Lipase (<70)							
Amylase (25-130)							
CK (<160)							
Troponin (<0.2)							
Lactate (0.5-2)							
HAEMATOLOGY							
HCT (0.39-0.52)							
Hb (120-170)							
WCC (4.0-10.5)							
PT Sec							
APPT (25-38)							
Platelets (150-400)							
Fibrin (1.5-4.0)							
INR (0.9-1.3)							

Donor Number	MRN	Date of Birth	
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PLASMA DILUTION - INFUSION / TRANSFUSION WORKSHEET

DEFINITIONS

'**blood**' refers to whole blood or red blood cells

'**colloid**' means a protein or polysaccharide solution that can be used to increase or maintain osmotic (oncotic) pressure in the intravascular compartment such as, dextran, haemacel, gelofusine or certain blood components, such as albumin, plasma, platelets, cryoprecipitate.

'**crystalloid**' means a balanced salt and / or glucose solution used for electrolyte replacement or to increase intravascular volume such as normal saline, hartmann's solution or 5% glucose in water.

STANDARD ARCBS BLOOD AND BLOOD PRODUCT VOLUMES PER UNIT

Whole Blood	450mls	Cryoprecipitate	40mls
Packed Red Cells	240 mls	4% Albumin	50 or 500mls
Fresh Frozen Plasma	150-300 mls	20% Albumin	10 or 100mls
Platelets	160mls		

Sample Date	/	/	Sample Time	:	hrs	Donor Weight	(kg)	
Plasma Volume (PV) = donor weight (kg)	x 40	=			mls			
Blood Volume (BV) = donor weight (kg)	x 67	=			mls			
A total volume of blood transfused in previous 48hours								
			Whole blood		mls			
			Packed cells		mls			
					mls = A			
B Total volume of colloids infused in previous 48hours								
			Platelets		mls			
			Fresh Frozen Plasma		mls			
			Albumin		mls			
			Cryoprecipitate		mls			
			Dextran		mls			
			Gelofusine / Haemacel		mls			
			Other		mls			
					mls = B			
C Total volume of crystalloid infused in previous 1 hour								
			Normal Saline		mls			
			5% Dextrose		mls			
			Hartmann's		mls			
			Other		mls			
					mls = C			
DETERMINATION OF SUITABILITY								
1 Is B + C > Plasma Volume?			Yes / No		2 Is A + B + C > Blood Volume?			Yes / No
If the answer to both 1 and 2 are NO then the post transfusion/infusion sample is acceptable								
If the answer to either 1 or 2 is YES then obtain a pre-transfusion/infusion sample								
Name in writing			Signature			Date / /		

Donor Number	MRN	Date of Birth	
Donor Name Date of Birth Medical Record Number Address		ID Label	

Persons Interviewed regarding history: Name _____ Address _____ Phone Number _____ Relationship _____	Persons Interviewed regarding history: Name _____ Address _____ Phone Number _____ Relationship _____
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GP / Clinic (most recent) _____ Address _____ _____ Phone Number _____	GP / Clinic (Previous) _____ Address _____ _____ Phone Number _____
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In order to proceed with organ and tissue donation, it is necessary for us to ask you some questions about (donor's name) medical and lifestyle history. All information will be treated in the strictest confidence.

Do you feel that you knew (him/her) well enough to answer questions about their medical and lifestyle history? Yes / No

If no, is there someone who might know? Yes / No

Name _____	Name _____
Phone _____	Phone _____
Address _____ _____	Address _____ _____
Relationship _____	Relationship _____

PAEDIATRIC DONOR INFORMATION

For paediatric donors < 18 months of age or who have been breastfed in the past 6 months, the mother is required to answer these questions with regard to both her own and her child's health.

Donor Number	MRN	Date of Birth	
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GENERAL HEALTH INFORMATION

ELABORATE ON ALL QUESTIONS ANSWERED 'YES'

1. Does (he/she) have any allergies? If yes, what? _____ Yes / No
2. Has (he/she) ever had any serious illnesses, infections, surgery or been admitted to hospital? _____ Yes / No

3. Has (he/she) ever have cancer of any kind including melanoma, skin cancer or leukaemia? _____ Yes / No
 If yes, were they treated with chemotherapy or radiotherapy? _____

4. Did (he/she) take any medication, including vitamins or herbal remedies on a regular basis? _____ Yes / No

5. Has (he/she) ever had heart problems, rheumatic fever , heart murmur or chest pain? _____ Yes / No
 Is there any family history of heart disease? _____ Yes / No

6. Did (he/she) have a history of high blood pressure? _____ Yes / No
 If yes, for how long? _____
 Treated with? _____
7. Has (he/she) ever had any lung problems including asthma or tuberculosis? _____ Yes / No
 Is there any family history of lung disease? _____ Yes / No

8. Did (he/she) smoke tobacco or any other substances? _____ Yes / No
 If yes, what did they smoke? _____
 How much did they smoke? _____
 How long did they smoke for? _____
 Had they given up smoking? If so when? _____
9. Did (he/she) ever have any liver diseases such as jaundice or hepatitis? _____ Yes / No
 Have they had close contact, in the last 12 months, with anyone who was diagnosed with hepatitis? _____ Yes / No

10. Did (he/she) drink alcohol? _____ Yes / No
 What did he/she drink _____
 How much and how often? _____
11. Did (he/she) ever have any kidney problems? _____ Yes / No
 Is there any family history of kidney disease? _____ Yes / No

12. Did (he/she) have a history of diabetes? _____ Yes / No
 If yes, how long has he/she been diabetic for? _____
 Was he/she treated with tablets or insulin injection? _____
13. Was (he/she) vaccinated or immunised in the last 12 months for any reason? _____ Yes / No
 If yes, what immunisation or vaccination, when, where, by whom? _____

14. Has (he/she) ever been treated for exposure to a toxic substance eg lead, pesticides? _____ Yes / No

Donor Number	MRN	Date of Birth	
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TRAVEL RISK

15. Has (he/she) ever travelled outside of Australia or New Zealand? _____ Yes / No
 If no, go to question 17
 If yes, when, where and for how long? _____

16. Did (he/she) spend 6 or more consecutive months in the United Kingdom (England, Ireland, Scotland, Wales, Channel Islands, Isle of Man) from the beginning of 1980 through to the end of 1996? _____ Yes / No
 If yes, when, where, length of time? _____

17. Has (he/she) ever had Malaria, Typhus, Ross River Fever, Q fever, Leptospirosis, Toxoplasmosis, West Nile virus or Chaga's disease ? _____ Yes / No

"WINDOW PERIOD" VIRAL INFECTION

18. In the last 6 months has (he/she) had a tattoo, ear or other body piercing, acupuncture or cosmetic treatments that involve piercing the skin? _____ Yes / No

19. Has (he/she) been injured with a used needle? _____ Yes / No

20. Has he/she had a blood or body fluid splash to eyes, mouth, nose or broken skin? _____ Yes / No

21. In the last 6 months has (he/she) had any history of unexplained infection, fever, weight loss, swollen glands, persistent cough or night sweats? _____ Yes / No

LIFESTYLE

22. Did (he/she) ever inject, been injected with or inhale any drugs, even once or a long time ago, which weren't prescribed by a doctor, including body building drugs? _____ Yes / No

23. Had (he/she) been in prison or a psychiatric facility in the last 12 months? _____ Yes / No

24. Has (he/she) been sexually active in the past five years? _____ Yes / No

(IF THE ANSWER IS 'NO' THEN REMAINING QUESTIONS IN THIS SECTION MAYBE OMITTED)

25. Male: to the best of your knowledge has he been sexually active with another male in the last 5 years? _____ Yes / No
Female: within the last 12 months, has she been sexually active with a male who has been sexually active with another male? _____ Yes / No

26. Has (he/she) engaged in sex in exchange for money or drugs in the past 5 years or ever been sexually active with anyone who has engaged in sex in exchange for money or drugs in the past 5 years? _____ Yes / No

27. Has (he/she) been sexually active in the past 12 months with any person known or suspected to be infected with HIV, Hepatitis B or Hepatitis C? _____ Yes / No

28. Has (he/she) been sexually active with anyone who has been in prison in the past 12 months? _____ Yes / No
 If yes do you know when? Facility? _____

29. In the past 5 years has (he/she) been sexually active with anyone who has used a needle for self-injection of drugs for anything other than medical purposes? _____ Yes / No

30. In the last 12 months has (he/she) been diagnosed with or treated for a sexually transmitted disease, such as Syphilis, Gonorrhoea or Herpes? _____ Yes / No

Donor Number	MRN	Date of Birth	
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TISSUE DONATION - INCLUDE THE FOLLOWING QUESTIONS

TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES

31. Did (he/she) ever receive human growth hormone for short stature or human pituitary hormone for infertility prior to 1986? _____ Yes / No
32. Do you know if (he/she) or anyone in the family has or had
- Creutzfeldt- Jacob Disease (CJD)? _____ Yes / No
 - Gerstmann - Straussler-Scheinker Syndrome?(GSS)? _____ Yes / No
 - Fatal Familial Insomnia (FFI)? _____ Yes / No
33. Did (he/she) have any type of diagnosed brain disease such as dementia, Alzheimer's, Multiple Sclerosis, Parkinson's disease or Motor Neurone disease? _____ Yes / No
34. Did (he/she) ever receive a blood transfusion or have treatment with plasma clotting factors here or overseas? _____ Yes / No
35. Did (he/she) ever receive a human organ or tissue transplant or an animal tissue transplant or graft such as bone, skin, cornea, dura mater, heart valve or veins? _____ Yes / No
36. Did (he/she) have any history of an autoimmune disease such as Systemic Lupus Erythematosus, Rheumatoid arthritis, Sarcoidosis, Polyarteritis Nodosa or Scleroderma? _____ Yes / No

EYE TISSUE

37. Did (he/she) have any history of eye diseases, infection, cataracts, corneal disease or operations involving the eyes, including laser vision correction (lasik) _____ Yes / No
If yes, when, where, treating doctor? _____

BONE TISSUE

38. Did (he/she) have any history of arthritis, bone or joint diseases eg osteoporosis, osteoarthritis, osteomyelitis, Paget's disease? _____ Yes / No

SKIN TISSUE

39. Did (he/she) have a history of skin infections such as leprosy, eczema, dermatitis or inflammatory skin conditions or abrasions _____ Yes / No

Thank you for participating in this interview. There are some people in the community who must not donate tissue or organs for transplantation due to the potential of transmitting infections to the people who receive the tissue or organs.

Is there anything else you can think of that may be significant in relation to their health or lifestyle? _____ Yes / No

RECORD OF ORGAN OFFERS AND ALLOCATION

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

RECORD OF ORGAN OFFERS AND ALLOCATION

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

RECORD OF ORGAN OFFERS AND ALLOCATION

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

ORGAN		X- MATCH NAME	X- MATCH
State			POS NEG
Coordinator			POS NEG
Contact number			POS NEG
Time offered			POS NEG
Time accepted / declined			POS NEG
Reason	NSR	NMS	LOG
Explanation			
Request			

FINAL ORGAN PLACEMENT - RECIPIENT INFORMATION

Organ	Surname	Christian Name	State	Hospital	Tissue	State	Bank
Liver					Eye		
Liver (left)							
Liver (right)					Heart Valve		
Heart							
Lungs					Bone		
Lung (left)							
Lung (right)					Skin		
Kidney (left)							
Kidney (right)					Other		
Pancreas							
Islets					Research		

PERI-OPERATIVE INFORMATION

OR phone number	.....	Viewing	Y / N
Contact person in OR	.....	Facilitated by:	.....
Booked start time	.....	Place of viewing:	.....
Arrival time in OR	.....	Transport to morgue:	.....
X-clamp time	.....	
Other events	.....	
		
		
		

DONOR HOSPITAL STAFF

ICU	Operating Room	Anaesthetics
		Other

RETRIEVAL TEAMS

Abdominal	Thoracic	Tissue

TRANSPORT

Donor Coordinator	Contact Number	Date of Birth	Donor Number	MRN
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ORGANS RETRIEVED	Heart <input type="checkbox"/>	Lungs <input type="checkbox"/>	Liver <input type="checkbox"/>	Kidneys <input type="checkbox"/>	Pancreas <input type="checkbox"/>
ABO SUBTYPE	DONOR HLA	A	B	DR	DQ

	TIME	DATE	INTRAOPERATIVE DRUGS	DOSE	DATE	TIME
Brain death			Methylprednisolone			
AORTIC CROSS CLAMP (local)			Heparin			
Cardiac standstill			Chlorpromazine			
Perfusion commenced			Prostacycline			
Warm ischaemia duration (if any)						

PERFUSION SOLUTIONS Portal Flush yes no (circle)				ORGAN STORAGE SOLUTIONS (circle)		
1 ST FLUSH	VOLUME	2 ND FLUSH	VOLUME	LIVER	KIDNEYS	PANCREAS
0.9% NaCl	ml	UW	ml	UW	0.9% NaCl	0.9% NaCl
Hartmann's	ml	HTK	ml	HTK	Hartmann's	Hartmann's
UW	ml				UW	UW
Ross	ml				Ross	Ross
HTK	ml					

ANATOMY & PERFUSION	RIGHT KIDNEY				LEFT KIDNEY				LIVER				PANCREAS			
Quality of Perfusion (circle)	1 worst	2	3	4 best	1 worst	2	3	4 best	1 worst	2	3	4 best	1 worst	2	3	4 best
Appearance after perfusion																
Arteries number / type																
Veins number / type																
Ureters - number	single	double	triple		single	double	triple									
Aortic Plaque	nil	mild	moderate	severe	nil	mild	moderate	severe	nil	mild	moderate	severe	nil	mild	moderate	severe
Arterial Plaque	nil	mild	moderate	severe	nil	mild	moderate	severe	nil	mild	moderate	severe	nil	mild	moderate	severe
Haematoma		Yes	No			Yes	No			Yes	No			Yes	No	
Fatty										Yes	No			Yes	No	
Biopsy		Yes	No			Yes	No		Yes	No	____% Fat		Yes	No		
Anatomy		normal	abnormal			normal	abnormal			normal	abnormal			normal	abnormal	
Surgical Damage		Yes	No			Yes	No			Yes	No			Yes	No	

Abnormal anatomy / surgical procurement issues / reason not retrieved

SURGEONS	1.	2.	3.
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Donor Coordinator	Contact Number	Date of Birth	Donor Number	MRN
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ORGANS RETRIEVED	Heart <input type="checkbox"/>	Lungs <input type="checkbox"/>	Liver <input type="checkbox"/>	Kidneys <input type="checkbox"/>	Pancreas <input type="checkbox"/>
ABO SUBTYPE	DONOR HLA	A	B	DR	DQ

	TIME	DATE	INTRAOPERATIVE DRUGS	DOSE	DATE	TIME
Brain death			Methylprednisolone			
AORTIC CROSS CLAMP (local)			Heparin			
Cardiac standstill			Chlorpromazine			
Perfusion commenced			Prostacycline			
Warm ischaemia duration (if any)						

PERFUSION SOLUTIONS				ORGAN STORAGE SOLUTIONS		
Cardioplegia / Flush		Pneumoplegia / Flush		HEART	LUNGS	HEART LUNG BLOC
0.9% NaCl	ml	Crystalloid based	ml	0.9% NaCl	0.9% NaCl	0.9% NaCl
Hartmann's	ml	Colloid based	ml	Hartmann's	Hartmann's	Hartmann's
Celsior	ml	Perfadex	ml	Celsior	Perfadex	Perfadex

HEART	HEART / HEART for VALVES (circle)					
Anatomical Abnormality?	Yes No comment					
Cardiovascular Disease?	Yes No comment					
Surgical Procurement Issues?	Yes No comment					
HEART FOR VALVES <u>Storage Solutions</u> Transplant - 0.9% NaCl Research - Hartmann's	Storage Solution Manufacturer Batch Number Expiry Date			Sterile Bag Manufacturer Batch Number Expiry Date		
LUNGS	RIGHT	LEFT	DOUBLE	HEART / LUNG BLOC (circle)		
Anatomical Abnormality?	Yes No comment					
Surgical Procurement Issues?	Yes No comment					
Intraoperative Bronchoscopy?	Yes No comment					
SURGEONS						

