

ORGAN, EYE AND TISSUE DONOR REFERRAL WORKSHEET



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Transplant Assessment

 Referral completed by: Attending MD Nurse Designate

Date: _____

Time of call: _____

Referring individual: (printed name) _____ Position: _____

Signature: _____ Contact number: _____

Hospital unit: _____ Direct unit phone number: _____

A Determination of Medical Suitability for Tissue Donation

Patient currently on a ventilator: Yes NoPreviously ventilated: Yes No

Date / Time of admission: _____

Cause of death: _____

CALL REFERRAL LINE: 1-877-DONOR-BC(1-877-366-6722)

 Referral line advice: **POTENTIAL DONOR** - wait for call from Retrieval Agency, See Section B
 NOT SUITABLE - No further action required. File this worksheet in chart.

DONOR BC Reference Number: _____

Coroner's Office notified: No Yes - Coroner's Name: _____

B Comment by Retrieval Agency (Agency will call referring individual)

 BCTS contact name: _____ Suitable NOT suitable

 Eye Bank contact name: _____ Suitable NOT suitable

NOTE: If NOT suitable for any tissue donation - File worksheet in chart

C Donor Registry confirmed by Retrieval Agency (BCT/EBBC) Yes No

 Registered Not registered

NOTE: If NOT suitable for any tissue donation - File worksheet in chart
Distribution: Place original form in the Patient's chart next to the Notice of Death
 Second copy to unit Patient Services/Medical Manager.

CRITERIA FOR ORGAN DONATION:

Age: No age restrictions
 End of Life considerations

- Call for EVERY patient that meets these criteria
- Call PRIOR to extubation

CRITERIA FOR EYE DONATION

Age: 2 years of age up to and including
 75 years of age

- Call **for** EVERY patient 2 to 75 years of age
- Call within 1 hour of the time of death
- Call when patient on comfort care is declining in their final days