ORGAN / EYE / TISSUE DONOR REFERRAL WORKSHEET

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 ☐ No

Previously 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