Tennessee Donor Services
an extraordinary commitment to science, health and hope

Call **1-800-969-4438** within one hour after death. TDS will evaluate the patient's donor registry status and medical suitability. If the patient is medically suitable, family services will contact the family about donation.

You will need the medical chart during the entire referral process.

First name:		**Last name:**	
MRN:			
Date of Birth: __ / __ / ____	**Sex:** ☐ M ☐ F	**Height:**	**Check if applicable:** ☐ HIV
Admit time: __ / __ __:__			
Time of death: __ / __ __:__	**Race:**	**Weight:**	☐ Hep B / C
Last Time Known Alive: __ / __ __:__			☐ Any Cancer
Cause of death to be listed on death certificate:			

Is there any documentation in the chart regarding donation wishes? If so, please be prepared to provide a copy to TDS.

Admitting diagnosis & events leading to death:

Any past medical history, specifically: RA, Alzheimer's, DM, COPD, Lupus, MS, Parkinson's, ALS, Dementia

Any record of sepsis? ☐ Y ☐ N	**Last 3 WBC's**		**Last 3 Temperatures**	
	Date	**Count**	**Date**	**Temp**
	__ / __		__ / __	
Date Documented: __ / __	__ / __		__ / __	
Was it resolved? ☐ Y ☐ N	__ / __		__ / __	

Any Blood Cultures:			**Any Positive Cultures:**			**Antibiotics from this admission:**		
Date	**Pos/Neg**	**Organism**	**Date**	**Source**	**Organism**	**Name**	**Start**	**Dosage**
__ / __	☐ P ☐ N		__ / __				__ / __	
__ / __	☐ P ☐ N		__ / __				__ / __	
__ / __	☐ P ☐ N		__ / __				__ / __	

Please have MAR and any Chest X-Ray or other Imaging results available for review.

Any skin conditions identified on back, legs and/or abdomen:

Condition	**Y / N**	**Description**
Moles	☐ Y ☐ N	
Skin Tearing	☐ Y ☐ N	
Bruising	☐ Y ☐ N	
Tattoos	☐ Y ☐ N	
Jaundice	☐ Y ☐ N	

Infusions given during past 48 hours:

Product	**Date / Time**	**Amount**
PRBC:	__ / __ __:__	
Albumin	__ / __ __:__	
Plasma	__ / __ __:__	
Cryo	__ / __ __:__	
TPN	__ / __ __:__	

As part of your hospital's aftercare process, TDS will offer the family of each potential donor the opportunity of donation.

Provide contact information for all family members and friends of the patient obtained by the hospital.

Name: _____ **Relationship to Patient:** _____ **Phone:** (___) - ___ - ____
Name: _____ **Relationship to Patient:** _____ **Phone:** (___) - ___ - ____
Name: _____ **Relationship to Patient:** _____ **Phone:** (___) - ___ - ____

Has a funeral home been selected? ☐ Y ☐ N

Funeral home name and location: **Phone number** (___) - ___ - ____

Medical examiner / coroner case? ☐ Y ☐ N **If yes, who requested autopsy?**

Phone number of who was spoken to regarding autopsy: (___) - ___ - ____

Cooling should start immediately after the time of death for optimum donation outcomes.
This is meant as a tool and not part of the permanent patient record.