



Next Steps Worksheet

Trillium Gift of Life Network
 Provide information to the Provincial Resource Centre
 1-877-363-8456 or 416-363-4438

TGLN # _____

To further assess donation potential, The Provincial Resource Centre Coordinator will ask you some or all of the following:

1. Admission History/Course of Events:
2. Cancer History:
3. Past Medical History:
4. List patient medications (all including PRN at TOD):

5. Was the patient on antibiotics within the last two weeks? Yes ____ No ____
 If Yes, which one(s)?

Abx	Duration	Reason

6. Most recent WBCs (white blood cell count) and temperatures:

Date	Time	WBC

Date	Time	Temp

7. Most recent Cultures:

Type	Date	Results
Blood		
Sputum		
Urine		

8. Did the patient have active sepsis? Yes ____ No ____
9. Last chest x-ray within two weeks? Day _____ Month _____ Year _____
 - a. Did it indicate pneumonia/consolidation? Yes ____ No ____



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Just a few more questions...

10. Does the patient have Diabetes? Yes ___ No ___ If yes, Type 1 ___ or Type 2 ___

11. Name of Family Physician: _____ #: _____

12. Name of Attending/Pronouncing Physician: _____

13. Coroner's Case? Yes ___ No ___ Name of Coroner: _____

14. Autopsy Pending? Yes ___ No ___

a. In hospital ___ Patient being transferred to: _____

15. What is the patient's height and weight?

a. Height: _____ cm / ft Estimated or Actual

b. Weight: _____ kg / lbs Estimated or Actual

16. Did the patient receive IV fluids (N/S, D5W, Ringers, etc.) in the hour before death?

Type	Amount

17. Did the patient receive blood or blood products (FFP, albumin, etc.) in the last 48 hours before death?

Type	Amount

Thank you for your time.

***TOD – time of death**

Note: This form contains confidential personal information. Please retain or dispose in accordance to hospital policy.