図 19　スキンバンクネットワーク　機能一覧

1．メインシステム

■ ログイン

- ID、パスワードを入力して起動する
- USB メモリを使用し、起動時についているか確認する
- ３つのセキュリティレベルを設け、使用できる機能を制限
  - Guest（参照のみ、一部データの参照不可（ドナー名など））
  - User（入力データの更新可能）
  - Admin（確定保存、研究用ロット登録等可能）

■ ドナー

- ドナーのリスト表示
  - ログイン後、ドナーリストを表示
  - ドナーの状態（確定保存等をアイコンで表示）
  - ドナーのリスト項目（ロットナンバー、出庫許可、採皮日、提供病院、地域、都道府県、合計単位、合計枚数、残り単位、残り枚数）
  - ドナーのソート（各リスト項目でソートを行う）
  - ドナーの検索（採皮日の範囲、ロットナンバー、地域等で前方一致検索）
  - 検索結果をリストに表示し、その内容を簡易的に統計（合計枚数、合計単位、平均枚数、平均単位）
- ドナーの新規登録（User,Admin 権限必要）
  - ロットナンバーを入力して新規にドナーを作成
  - 作成日、更新日、更新者を記録
- ドナー情報の入力、編集（User,Admin 権限必要）
  - ドナー情報

    提供病院、ドナーについて、同意プロセス、使用禁忌など
  - 全身評価

    画像を用いて、各部位の皮膚の状態を入力
  - 検査

    血清学的検査などの検査情報

    出庫の許可
  - タイムテーブル

    ドナー発生からのタイムテーブル、問題点など
  - 採皮情報

    チーム人員、タイムテーブル、採皮物品チェックなど

採皮部位については画像を使用する

- 皮膚管理

  入出庫データからデータを反映して表示

  各パックには、部位、枚数、保存場所、出庫先、出庫予定などの属性

  作業者、記録者の表示

  使用後はレシピエント情報とリンク

- フォローアップ

  採皮後、家族や病院へのフォローアップ

- ドナー情報の印刷
  - ドナー情報、皮膚保存リスト、タイムテーブルなどの印刷
- ドナーの確定保存（Admin 権限必要）
  - 出庫許可を出す一次確定保存
  - 全てのロットが出庫したら完全確定保存
  - 完全確定保存後は入力、修正不可

■ レシピエント

- レシピエントのリスト表示
  - レシピエントの状態（確定保存等をアイコンで表示）
  - レシピエントのリスト項目（ロットナンバー、BI、使用回数、施行日、出庫予定日、使用施設、地域、都道府県、必要単位、使用単位、状態）
  - レシピエントのソート（各リスト項目でソートを行う）
  - レシピエントの検索（施行日の範囲、ロットナンバー等で前方一致検索）
  - 検索結果をリストに表示し、その内容を簡易的に統計（ロット数、ロット人数、合計使用単位、平均使用単位）
- レシピエントの新規登録（User,Admin 権限必要）
  - ロットナンバーを入力して新規にレシピエントを作成
  - 作成日、更新日、更新者を記録
- レシピエント情報の入力、編集（User,Admin 権限必要）
  - レシピエント情報

    使用施設、熱傷状態など

    手術予定部位は画像を用いて入力

  - 経過情報

    移植後２週間後の状況、４週間後の状況など

    使用部位は画像を用いて入力

  - シッピング

    郵送したタンク、皮膚の質に関する追跡調査

入力項目の集計、表示

- レシピエント情報の印刷
  - レシピエント情報、結果などの印刷
- レシピエントの確定保存（Admin 権限必要））
  - 全てのデータ入力が終了したら確定保存
  - 確定保存日を表示
  - 確定保存後は入力、修正不可

■ タンク

- タンク一覧表示
  - タンクに保存されている皮膚の一覧を表示
  - 画像を用いてどこに保存されているか表示
  - 出庫許可の区分、予約状態などを表示

■ エディット

- マスタエディット（Admin 権限必要）
  - スタッフ、提供病院などのマスタデータを更新
- 入出庫データ取り込み
  - 入出庫管理端末の情報を USB にて共有化
  - 新規に登録されたドナー、レシピエント情報を出力
  - 入庫・・・ドナーの皮膚保存リスト、タンク一覧更新
  - 出庫・・・レシピエントの使用皮膚リスト、ドナーの皮膚保存リスト（出庫先）、タンク一覧更新

■ **研究用ロット**（Admin 権限必要）

- 研究用ロットの新規登録
  - 一般用に出庫の許可が出来ない皮膚についてはここで登録を行う
  - ロットナンバー、使用施設、使用者、目的、必要単位、出庫予定日を入力して新規登録を行う
- リスト表示
  - 新規登録時に入力したデータがリストに反映される
  - 特記事項としてあとから入力できる項目がある

2．入出庫システム

■ ログイン

- ID、パスワードを入力して起動する（指紋認証導入予定）
- USB がついているか確認

■ タンク一覧表示

- ログイン後、タンクの一覧を表示
  - タンクに保存されている皮膚の一覧を表示
  - 画像を用いてどこに保存されているか表示
  - 出庫許可の区分、予約状態などを表示

■ 入庫

- 入庫処理
  - USB から、入庫するドナーのロットナンバーを取得
  - 採皮部位、枚数などを入力
  - 保存するタンクの場所には画像を用いて入力
  - ロットナンバー、採皮部位、枚数、タンクの場所をもとにバーコードを発行
  - 入庫皮膚リストを作成し、入庫時にバーコードを読み取り照合
  - 入庫したドナーの情報を USB に出力

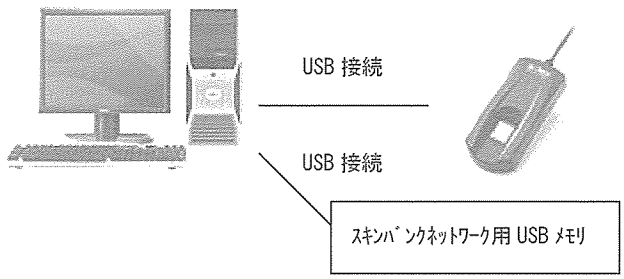
■ 出庫

- 出庫処理
  - USB から、皮膚を必要とするレシピエントのロットナンバーを取得
  - 事前に予約した皮膚の情報をリスト表示
  - 表示されたリストに従って、バーコードを読み取る
  - レシピエントに対して出庫したドナーの情報を USB に出力

- 入出庫履歴
  - 入庫、出庫のあったもののログをデータベース出力

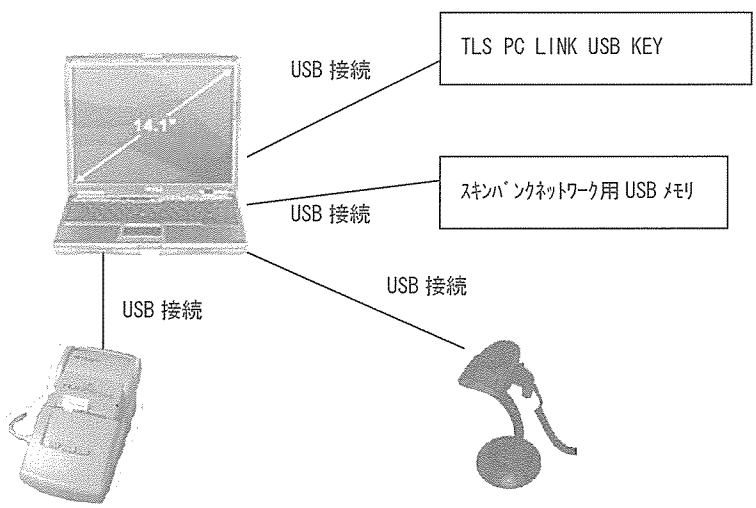
図 20　ｽｷﾝﾊﾞﾝｸﾈｯﾄﾜｰｸｼｽﾃﾑ(SNS)　ハードウェア構成

- メインシステム



・DELL Precision 380
　Pentium4 2Gb 80Gb*2SATA(raid1) WinXP-Pro sp2
　Office Pro 2003
　Oracle 9i
・FUS-200N（指紋認証装置）
・スキンバンクネットワーク用 USB メモリ（S ドライブ）＊共通

- 入出庫システム



・DELL Latitude D610
　PentiumM 512Mb 60Gb WinXP-Pro sp2
・TLS PC LINK （ラベルプリンタ）
・THLS-6800-USB（バーコードスキャナ）
・TLS PC LINK USB KEY（ラベルプリンタ用ライセンスキー）
・スキンバンクネットワーク用 USB メモリ（S ドライブ）＊共通

U.S. Tissue & Cell

ANATOMICAL GIFT FORM

1-800-833-6667

CONSENT FOR ORGAN, EYE & TISSUE DONATION

Donor Name _____ Hospital _____

Date of Death _____ Time of Death _____ City/State _____

I authorize Intermountain Donor Services, U.S Tissue and Cell, and Utah/Idaho Lions Eye Banks (hereafter referred to as recovery agencies) to obtain, photocopy, and release any information relevant to the evaluation, use, and follow-up of the donated organs and/or tissues. I further authorize any and all health care institutions and/or providers to release to recovery agencies any relevant medical records and autopsy reports. _____

I understand that the allocation and recovery will be coordinated by the recovery agencies in accordance with professional standards and nationally recognized policies. Actual processing and distribution of donated tissue may be done by other agencies. Confidentiality will be maintained; however, the recovery agencies are not responsible for information obtained from other sources. _____

I authorize the recovery agencies to perform those tests necessary to evaluate the safety of the organs and/or tissues for transplantation, including but not limited to those for communicable diseases such as hepatitis and HIV (AIDS). These test results will be kept confidential in accordance with applicable laws and policies. _____

I understand that the costs relating to the evaluation, maintenance, and recovery of donated organs and/or tissues will be paid by the recovery agencies. All other costs, including funeral and burial arrangements, are the responsibility of the family. _____

The estimated period of time required for the evaluation, allocation, recovery, and placement of surgical incision lines and recovery procedures have been explained. If necessary to facilitate the recovery of organs and/or tissues, the deceased may be transferred to another institution. _____

I am the legal next-of-kin. **Next-of-kin order of priority: spouse, adult child, either parent, adult sibling, grandparent, legal guardian, other relative or authorized person, medical examiner.** _____

The option of anatomical donation has been explained to me in a language that is understandable. I have made an informed decision to voluntarily consent to give the recovery agencies, after pronouncement of death and in accordance with the Uniform Anatomical Gift Act, the authority to remove the following organs and tissues:

Organs & Associated Anatomy	Yes	No	N/A	Tissues & Associated Anatomy	Yes	No	N/A
Heart				Whole eyes for corneas/sclera			
Lungs				Heart for valves			
Kidneys				Skin grafts			
Liver, liver for hepatocyte cells				Blood vessels of the abdomen			
Pancreas, pancreas for islet cells				Blood vessels of the leg			
Small bowel				Hipbone			
Spleen and lymph nodes for tissue typing purposes				Long bones of the arm, including soft tissue			
Organs/Tissues for Research/Education Yes____ No____				Long bones of the leg, including knee/ankle/soft tissue			

NEXT-OF-KIN (please print)

Name _____ Address _____

Signature _____ City/State _____

Relationship _____ Zip Code _____ Phone _____

WITNESS

Name _____

Signature _____

Telephone Consent ☐ Tape on File ☐

Consent obtained by:

Name _____

Signature _____

Organization: _____

Date/Time _____

RET-001 Rev:01 Effective 2/01/04

U.S. Tissue & Cell

MEDICAL / BEHAVIORAL RISK ASSESSMENT QUESTIONNAIRE

Donor Name: _____

Person Interviewed: _____ Relationship to Donor: _____

Person Conducting Interview
And Completing Form: _____ _____
Print Name Title

_____ _____ ___/___/___
Signature Location & Date of Interview

Do you feel you know the deceased well enough to answer questions regarding the med/soc history? ☐ Yes ☐ No

The interviewee should be instructed to answer all questions, "to the best of your knowledge". The interviewer ***must*** comment and elaborate on all questions marked "yes'.

1. Has the potential donor: a. Been treated by a physician in the past two years or have a family physician?	☐ No ☐ Yes, physician name and contact info _____
b. Been hospitalized in the past two years? Why and When?	☐ No ☐ Yes, Hospital _____
c. Been treated in a psychiatric facility in the past two years?	☐ No ☐ Yes, facility _____
2. Did the potential donor have any serious illnesses, infections or surgical procedures in the past? If yes, please list.	☐ No ☐ Yes
3. Did the potential donor take any medications, vitamins or supplements on a regular basis or recently? Please list.	☐ No ☐ Yes
4. Did the potential donor use tobacco products?	☐ No ☐ Yes
a. Cigarettes?	☐ No ☐ Yes packs per day_____ for _____years
b. Other?	☐ No ☐ Yes _____
c. Quit using tobacco products?	☐ No ☐ Yes _____ When?_____
5. Did the potential donor drink alcohol? How much and how long? What type? Beer / Wine / Hard Liquor (circle appropriate)	☐ No ☐ Yes Consumption Rate_____Years_____ Rarely / Socially / Weekly / Daily / Binge / Alcoholic (circle appropriate)
6. Did the potential donor ever use non-prescribed drugs or other substances, e.g. cocaine, marijuana, steroids, inhalants? What, how much and when? By what route?	☐ No ☐ Yes

Interviewers Initials/Date: _____ ___/___/___

Donor Name:_____ _____

U.S. Tissue & Cell

MEDICAL / BEHAVIORAL RISK ASSESSMENT QUESTIONNAIRE

7. Has the potential donor ever been exposed to toxic substances, e.g. lead, pesticides or other? When?	☐ No ☐ Yes _____
a. Did this result in symptoms or illness?	☐ No ☐ Yes _____
What was the deceased's occupation?	☐ N/A Occupation _____
8. In the past three years has the potential donor traveled outside of the United States (except Canada)? Describe where and when.	☐ No ☐ Yes _____
a. Been diagnosed or treated for malaria or Chagas disease?	☐ No ☐ Yes _____
b. Taken anti-malarial drugs?	☐ No ☐ Yes _____
c. Been in a malaria endemic area in the past year? (e.g., SE Asia, So. America, Africa, Middle East, Central Asia, & others)	☐ No ☐ Yes _____
9. Has the potential donor ever received blood transfusions or blood products? (prior to this admission)	☐ No ☐ Yes _____
When?	_____
10. Was the potential donor? a. Ever refused as a blood donor or told not to donate? Why? When?	☐ No ☐ Yes _____
b. Ever a blood donor?	☐ No ☐ Yes _____
11. Did the potential donor ever receive a human or animal organ or tissue transplant, e.g., bone, cornea, skin, heart valve, kidney, dura mater?	☐ No ☐ Yes _____
a. If yes what kind and when?	_____
b. Ever been in close contact with a person who received organ or tissue transplant from an animal?	☐ No ☐ Yes _____
c. If yes what kind and when?	_____
12. In the past 12 months did the potential donor have any of the following?	
a. Tattoo?	☐ No ☐ Yes _____
b. Ear/body piercing?	☐ No ☐ Yes _____
c. Acupuncture?	☐ No ☐ Yes _____
d. Accidental needle stick?	☐ No ☐ Yes _____
e. A bite in the past 12 months from an animal suspected of rabies?	☐ No ☐ Yes _____
If yes, provide details such as body site, when, by whom and how many?	_____ _____
If tattoo, describe content if known:	_____ _____
For a, b or c, were needles shared?	☐ No ☐ Yes _____

Interviewers Initials/Date: _____ ____/____/____

Donor Name: _____ _____

13. In the past 12 months was the potential donor: a. Vaccinated or immunized for any reason? b. Any in the past 8 weeks? What? When? c. Received **Smallpox** in the last 21 days or have they had contact with someone receiving the vaccine? d. Any signs of infection or complications? Was the potential donor vaccinated for hepatitis B?	☐ No ☐ Yes_____ ☐ No ☐ N/A ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ N/A ☐ Yes_____ ☐ No ☐ Yes_____
14. Was the potential donor ever given human pituitary derived growth hormone?	☐ No ☐ Yes_____
15. Did the potential donor have any history of: a. Heart disease? b. High blood pressure? For how long? c. Chest pain? d. Poor circulation especially in the legs? e. Leg ulcers? f. Taking medication for heart or blood pressure problems? If so, what?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ years ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ _____
16. Did the potential donor: a. Have any type of liver disease or hepatitis? b. Have any history of jaundice? c. Ever have a positive test for hepatitis? d. Live with or have sexual relations with persons diagnosed with viral hepatitis in the past 12 months?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____
17. Did the potential donor have: a. Any kidney related diseases? b. Kidney stones? c. Frequent infections? d. Kidney dialysis treatments? When and how long?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ _____
18. Did the potential donor have a history of: a. Digestive or intestinal problems? b. Bloody stools? c. Intestinal surgery or intestinal cancer? d. Recent weight loss? How much? Reason?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____
19. Did the potential donor: a. Have a history of diabetes? b. If yes, did he/she require medication? Name of medication? Length of treatment? c. Have a history of gestational diabetes?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ _____ ☐ No ☐ N/A ☐ Yes_____

Interviewers Initials/Date: _____ ____/____/____

Donor Name:_____ _____

20. Did the potential donor have any history of: a. Lung disease? b. Asthma? c. Emphysema? d. A positive skin test for tuberculosis? If yes, was there follow-up? e. Treatment for tuberculosis (TB)? When?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____
21. Has the potential donor: a. Ever had cancer? What type? When? b. Ever received radiation therapy or drugs for cancer?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ number of years free of cancer _____years date of last check up _____
22. Did the potential donor have a history of any of the following autoimmune diseases: a. Rheumatoid arthritis? b. Systemic lupus erythematosus? (chronic inflammation – body) c. Polyarteritis nodosa? (widespread vascular inflammation, necrosis) d. Sarcoidosis? (formation of tubercles in lung,spleen,liver,lymph,etc) e. Other autoimmune disease?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____
23. Did the potential donor suffer from any type of neurologic or brain disease such as: a. Alzheimer's, Parkinson's, or MS? b. Seizures? c. Periods of confusion or recent memory loss? d. History of brain tumor? e. Polio or degenerative neurological disease? f. Encephalitis? g. Any unexplained difficulty thinking, speaking, jerky or involuntary movements, or difficulty with coordination? Has the potential donor or any of the donor's blood relatives had Creutzfeldt-Jakob Disease (CJD)? Or been told they were at risk for CJD?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____
24. Did the potential donor have any history of bone or joint disease? a. Rheumatoid arthritis? b. Other arthritis? c. Osteoporosis? d. Osteomyelitis? e. Broken bones? Was the potential donor physically active (i.e. exercise regularly, take walks, participate in sports, etc.)?	☐ No ☐ Yes _____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____
25. Did the potential donor have a history of skin infections such as leprosy, eczema, dermatitis or inflammatory skin diseases?	☐ No ☐ Yes_____

Interviewers Initials/Date: _____ ____/____/____

Donor Name:_____ _____

CURRENT FDA/AATB CRITERIA FOR HIGH RISK BEHAVIOR	
26. In the past twelve months has the potential donor had or been treated for any sexually transmitted disease such as syphilis, gonorrhea, genital herpes or venereal warts? Or had sexual relations with such an individual?	☐ No ☐ Yes_____ _____ ☐No ☐ Yes_____
27. Has the potential donor recently exhibited or experienced: a. Unexplained weakness, fatigue or flu-like symptoms such as persistent cough, cold, shortness of breath, swollen lymph nodes for greater than one month b. Nausea, vomiting, persistent diarrhea c. Night sweats or fever >100.5° F. for greater than 10 days? d. Blue or purple spots on the skin or mucous membranes? e. Significant weight loss or opportunistic (unusual) infections?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____ ☐ No ☐ Yes_____
28. Has the potential donor ever had a positive test for HIV? Has the potential donor been tested for HIV? When? Result?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____ _____ _____
29A. Male Donors: Has the potential donor had sexual relations with another male in the past 5 years or ever? 29B. Female Donors: Has the potential donor had sexual relations with males who have had sex with other males in the past 5 years or ever?	☐ No ☐ N/A ☐ Yes _____ ☐ No ☐ N/A ☐ Yes_____
30. Has the potential donor ever used a needle to inject drugs into the vein, muscle, or under the skin for nonmedical use? Or had sexual relations with such an individual in the past 12 months?	☐No ☐ Yes When? _____ _____ ☐ No ☐ Yes_____
31. Has the potential donor received human-derived clotting factor concentrates for hemophilia or related clotting disorders? Or had sexual relations with such an individual in the past 12 months?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____
32. Has the potential donor engaged in sex in exchange for money or drugs in the past 5 years? Or had sexual relations with such an individual in the past 12 months?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____

Interviewers Initials/Date: _____ ____/____/____

Donor Name:_____ _____

33. Was the potential donor exposed to known or suspected viral hepatitis or HIV-infected blood through accidental needle stick or through contact with an open wound, non-intact skin, or mucous membrane in the past 12 months? Or had sexual relations with such an individual in the past 12 months?	☐ No ☐ Yes_____ ☐ No ☐ Yes_____
34. Has the potential donor had sex in the past 12 months with any person known or suspected to have viral hepatitis or HIV infection?	☐ No ☐ Yes_____
35. Has the potential donor: a. Ever been in jail? When? How long? b. Was the deceased an inmate of a correctional system (including jails and prisons) for more than seventy-two (72) consecutive hours in the past twelve (12) months?	☐ No ☐ Yes _____ ☐ No ☐ Yes_____
PEDIATRIC DONORS	
36. A. Was the child 18 months of age or less?	☐ No ☐ Yes_____
36. B. If under 5 years of age, was the child breast-fed within the past 12 months?	☐ No ☐ Yes_____
If the answer to either question 36A or 36B is yes, to determine if a pediatric donor was born to a mother with or at risk for HIV or viral hepatitis infection, a separate Medical History and Behavioral Risk Assessment questionnaire must be completed for the mother.	
EYE DONORS	
37. Did the potential donor have a history of diseases, infections, or surgeries involving the eyes? a. Glaucoma? b. Cataracts? c. Corneal disease? d. Laser surgery? e. Radial keratotomy? f. Macular degeneration? g. Retinitis Pigmentosa Did the potential donor have an eye physician? Name of Eye Doctor:_____(if known)	☐ No ☐ Yes_____ a☐ No ☐ Yes_____ b☐ No ☐ Yes_____ c☐ No ☐ Yes_____ c☐ No ☐ Yes_____ e☐ No ☐ Yes_____ f☐ No ☐ Yes_____ g☐ No ☐ Yes_____ ☐ No ☐ Yes Treatment facility_____ Telephone number of facility if known_____
ALL DONORS	
38. Having answered many questions about medical diseases and behavioral risk factors, do you now have any concerns that it might not be safe to proceed with organ or tissue donation?	☐ No ☐ Yes_____

Interviewers Initials/Date: _____ ____/____/____

Donor Name:_____ _____

Who first approached you about donation? _____

Had the deceased made any indication of their wishes for donation? Driver's License, Donor Card, Registry: ☐ Yes ☐ No

Are there other individuals that may provide additional information regarding any of these questions? ☐ Yes ☐ No

IF YES,

Name: _____

Telephone: _____

Relationship: _____

ADDITIONAL COMMENTS: (please refer to question numbers where applicable)

Interviewers Initials/Date: _____ ____/____/____

Donor Name: _____

SARS / West Nile Virus Addendum

1. Was the potential donor diagnosed with SARS or suspected to have SARS? ☐ No ☐ Yes
   If yes:
   When?_____
   How long did symptoms last?_____
   When was treatment stopped?_____

2. Did the potential donor have close contact with someone with SARS or suspected to have SARS? ☐ No ☐ Yes
   If yes:
   When?_____

3. Did the potential donor travel outside the United States in the past 12 months (this includes travel to Canada? ☐ No ☐ Yes
   If yes:
   When?_____
   Where?_____

WNV Questioning

1. Did the potential donor have a fever with headache in the past week? ☐ No ☐ Yes
   If yes:
   Confirm that *both* symptoms occurred *together*: ☐ No ☐ Yes

   If no, explain:_____

   If yes:
   Were any of the following symptoms *also* experienced:

Eye pain	☐ No	☐ Yes
Body aches	☐ No	☐ Yes
Generalized weakness	☐ No	☐ Yes
Skin Rash	☐ No	☐ Yes

Interviewers Initials/Date: _____ ____/____/____

Donor Name: _____

U.S. Tissue & Cell

TISSUE DONOR INFORMATION FORM

USTC Donor ID#_____

Donor Name (Last, First, MI): _____, _____, _____

Age/Sex/Race _____ / M F / _____ Date of Birth: ____/____/____
(Circle One)

Hospital: _____

City/State: _____ / _____

Recovery Site (if different from Hospital): _____

Hospital Number / SSN (Circle); _____

Admission Date/Time: _____

Attending/Primary Physician (Circle): _____

Initial Cause of Death: _____

Final Cause of Death: _____

Specify date/time of cardiac death: Type (check box that applies) :

☐ time last known alive
☐ pronounced asystole
☐ cross-clamp

Date:____/____/____ Time:_____

Specify date/time of brain death:

Date:____/____/____ Time:_____

Specify date/time body subjected to refrigeration prior to recovery ☐ Check if not cooled

Date:____/____/____ Time:_____ Method: _____

Autopsy: ☐ Yes ☐ No Required by: ☐ M.E. ☐ Hospital ☐ Family

Medical Examiner or Pathologist (if applicable):_____ Case #:_____

If an Autopsy is being performed, Tissue Recovery is: ☐ Pre-autopsy ☐ Post-autopsy

Clinical Course (Describe the events surrounding death, the manner/mechanism of death, and include pertinent treatments administered):

_____

_____

_____

_____

Approval of a Certified Tissue Bank Specialist of Medical Director must be obtained PRIOR to tissue procurement

CTBS Telephone Review: _____ Date: ____/____/____ Time: _____

CTBS Personal Review: _____ Date: ____/____/____ Time: _____

Coordinator Initials: _____ Date: _____

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U.S. Tissue & Cell

TISSUE DONOR INFORMATION FORM

USTC Donor ID#_____

Donor Physical Assessment

Height:_____ centimeters Height is: ☐ Estimated ☐ Reported

Weight:_____ kilograms Weight is: ☐ Estimated ☐ Reported

Infectious Isolation precautions known?	☐ Yes	☐ No
Non-medical injection of drugs?	☐ Yes	☐ No
Trauma or infection to tissue retrieval sites?	☐ Yes	☐ No
Genital lesions?	☐ Yes	☐ No
Blue/purple or gray spots/lesions?	☐ Yes	☐ No
Enlarged lymph nodes?	☐ Yes	☐ No
Jaundice?	☐ Yes	☐ No
Anal tears/perianal warts?	☐ Yes	☐ No
White spots in mouth?	☐ Yes	☐ No
Tattoos, piercings, scars, or deformities?	☐ Yes	☐ No

Explain if any above answers where "Yes":_____

_____

_____

_____

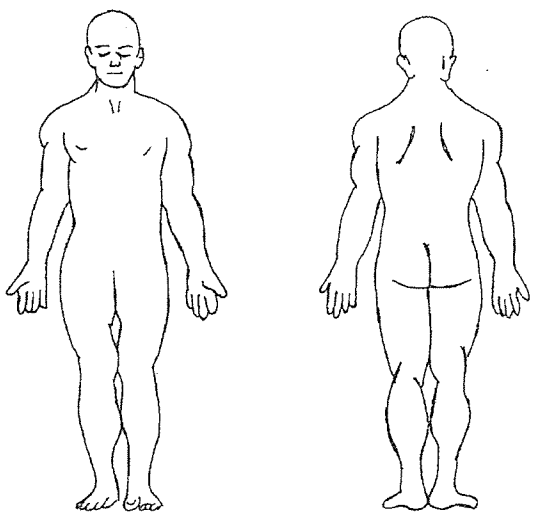
Body Identified by: ☐ Wrist Band ☐ Toe Tag ☐ Other (describe): _____

USTC Coordinator Identifying Body (signature): _____

USTC Staff Member #2 Identifying Body (signature): _____

USTC Coordinator Performing Assessment (signature): _____

Date/Time Physical Assessment Performed: Date:____/____/____ Time:_____



1__ Abrasion
2__ Amputations
3__ Bandage
4__ Body Piercing
5__ Break/Fracture
6__ Burn
7__ Contusion
8__ Dermatitis
9__ Endotracheal Tube
10__ Enucleation
11__ Fracture/Closed
12__ Fracture/Open
13__ Gun Shot Wound
14__ Hematoma
15__ ID Band
16__ Incision
17__ I.V. Tube/Catheter
18__ Laceration
19__ Moles/Nevi
20__ Puncture Site
21__ Rash
22__ Scar
23__ Tattoo
24__ Ulceration
25__ Other: _____
26__ Other: _____
27__ Other: _____
28__ Other: _____

Coordinator Initials: _____ Date: _____

U.S. Tissue & Cell

TISSUE DONOR INFORMATION FORM

USTC Donor ID#_____

USTC Infusion/Transfusion Record

Serology Panel

Agencies Involved in Recovery:	☐ USTC	☐ ULEB	☐ IDS	☐ Other:_____
Agency conducting main serology panel:	☐ USTC	☐ ULEB	☐ IDS	☐ Other:_____
Agency conducting HIV-1/HCV NAT:	☐ USTC	☐ ULEB	☐ IDS	☐ Other:_____
Serology Laboratories:	☐ ARUP	☐ Bonfils	☐ Viromed	☐ Other:_____

Date/time blood sample(s) drawn:

Date:_____/_____/_____ Time:_____

Date:_____/_____/_____ Time:_____

Plasma Dilution Algorithm

Donor Weight in kilograms (2.2 lbs = 1kg.): _____

Plasma Volume (PV) = Donor Weight (kg) divided by .025 **PV =** _____ **ml**

Blood Volume (BV) = Donor Weight (kg) divided by .015 **BV=** _____ **ml**

Is B + C > Plasma Volume (PV) ☐ Yes ☐ No

Is A + B + C > Blood Volume (BV) ☐ Yes ☐ No

If answer to both 1 and 2 are NO, then test sample, if either one is yes, than reject donor.

A. Total volume blood infused within 48 hours prior to specimen draw or asystole, whichever is first:

Type	Unit		VOLUME
Whole Blood		X 450 ml	ML
Packed RBC		X 350 ml	ML
Total			ML

B. Total volume blood products or colloids infused within 48 hours prior to specimen draw or asystole, whichever is first:

Type	Unit		VOLUME
FFP		X 250 ml	ML
Random Platelets		X 50 ml	ML
Single Donor Platelets		X 350 ml	ML
Cryoprecipitates		X 15 ml	ML
Albumin, Hetastarch, Hespan, Dextran, etc.			ML
Other:			ML
Total			ML

C. Total volume crystalloids infused in the hour prior to specimen draw or asystole, whichever is first:

Type	VOLUME
Normal Saline	ML
Dextrose in Water	ML
Ringer's Lactate	ML
Total	ML

Coordinator Initials: _____ Date: _____

U.S. Tissue & Cell

TISSUE DONOR INFORMATION FORM

USTC Donor ID#_____

Medical Record Review

Source of Documentation (*Check all that apply*): ☐ Medical Record ☐ Medical Social History Interview ☐ Other:_____

Evaluation for systemic infection:

Were temperatures recorded? ☐ Yes ☐ No If Yes, latest temperature: _____ Date:_____
High temperature: _____ Date:_____

Were WBC requested? (normal = 3600-1100) ☐ Yes ☐ No If Yes, latest WBC: _____ Date:_____

Was the potential donor on a respirator? ☐ Yes ☐ No If Yes, number of days:_____

Were blood cultures requested? ☐ Yes ☐ No If Yes, results: _____ Test Date:_____

Were sputum cultures requested? ☐ Yes ☐ No If Yes, results: _____ Test Date:_____

Were urine cultures requested? ☐ Yes ☐ No If Yes, results: _____ Test Date:_____

Neurological Disorders:

Alzheimer's ☐ Yes ☐ No Multiple Sclerosis ☐ Yes ☐ No

Amyotrophic Lateral Sclerosis ☐ Yes ☐ No Parkinson's Disease ☐ Yes ☐ No

Creutzfeld-Jacob Disease ☐ Yes ☐ No Other mental deterioration (specify): _____

Cancer, Malignancy, or Neoplasm:

Cancer, malignancy, or neoplasm ☐ Yes ☐ No

If Yes, Type: _____

History:_____

_____

Treatments:_____

_____

Hepatitis:

Does the donor have active hepatitis or signs/symptoms of Hepatitis B or C? ☐ Yes ☐ No If Yes, comment:_____

_____

_____

Did the potential donor have a chest X-ray? ☐ Yes ☐ No

Interpretation:_____

_____

_____

Significant Past Medical History:_____

_____

_____

_____

_____

_____

Hospital Medical Records returned to: _____ ☐ Check if N/A

Hospital Staff Signature: _____ Date:___/___/___ Time:_____

Coordinator Initials: _____ Date: _____

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TISSUE DONOR INFORMATION FORM

USTC Donor ID#_____

Tissue Recovery Report – Part 1

Location of tissue recovery: _____ Room: _____

The consent was reviewed ON-SITE and it is verified, understood, and agreed upon by team.

Each technician must initial here: _____ Time: _____

Recovery Times

Date/Time of prep start:	Date:___/___/___	Time:_____
Date/Time of first incision:	Date:___/___/___	Time:_____
Date/Time of skin placed on wet ice:	Date:___/___/___	Time:_____
Date/Time of last MS tissue wrapped and placed on wet ice:	Date:___/___/___	Time:_____

Tissues Recovered

Skin:

Scrub technician: _____ Circulator: _____

Musculoskeletal: (Specify recovery order)

Left Sequence:

Scrub technician: _____ Backtable: _____

☐ N/A _____ Fascia Lata	☐ N/A _____ Femur
☐ N/A _____ Patellar Tendon	☐ N/A _____ Humerus
☐ N/A _____ Tibia	☐ N/A _____ Iliac Crest
☐ N/A _____ Tibia w/ Pat. Tendon	☐ N/A _____ Other:_____
☐ N/A _____ Fibula	☐ N/A _____ Other:_____
☐ N/A _____ Achilles Tendon	☐ N/A _____ Other:_____

Right Sequence:

Scrub technician: _____ Backtable: _____

☐ N/A _____ Fascia Lata	☐ N/A _____ Femur
☐ N/A _____ Patellar Tendon	☐ N/A _____ Humerus
☐ N/A _____ Tibia	☐ N/A _____ Iliac Crest
☐ N/A _____ Tibia w/ Pat. Tendon	☐ N/A _____ Other:_____
☐ N/A _____ Fibula	☐ N/A _____ Other:_____
☐ N/A _____ Achilles Tendon	☐ N/A _____ Other:_____

Blood Tubes/culture labeling verified by: #1_____ #2_____

Policy and Procedure Deviation during Recovery? (Additional Documentation made on Coordinators Notes Form)

☐ Yes ☐ No If "Yes" explain: _____

_____

Procurement Notes (*i.e donor belongings, accidents, incidents*):_____

_____

_____

Coordinator Initials: _____ Date: _____

Tissue Recovery Report – Part 2

Donor Reconstruction

Donor body reconstructed?

☐ Yes ☐ No If "No" explain: _____

st☐ Prosthetics used ☐ Viscerock used Femoral artery intact: ☐ Yes ☐ No

Funeral Home Information

Funeral Home contacted by: ☐ USTC ☐ Hospital Staff ☐ Other: _____

Funeral Home Name: _____

_Phone Number:_____ Contact:_____

s Comments:_____

Recovery Finalization

Was recovery suite cleaned and left in a state of readiness?

☐ Yes ☐ No If "No" explain: _____

_Toe tag, personal belongings, and unionall left with body?

☐ Yes ☐ No If "No" explain: _____

_Copy of the Procurement Report and Consent form left with procurement facility?

☐ Yes ☐ No If "No" explain: _____

Coordinator Initials: _____ Date: _____