1.0 RECOVERY SITE ASSESSMENT (Performed as per *SOP-04-007 Recovery Site Assessment)*

Location of Recovery: _____

The recovery site was found to be acceptable as described in above procedure:

☐ Yes ☐ No (explain): _____

2.0 DONOR'S INFORMATION

Last name: _____ Middle Initial: _____ First name: _____

Age: _____ Sex: _____ Race: ☐ Caucasian ☐ Black ☐ Other _____

Donor Identified Via: ☐Toe Tag ☐ ID Bracelet ☐ Other (specify) _____

3.0 CONSENT INFORMATION VERIFICATION:

Consent granted for: ☐ Whole Eyes ☐ Corneas ONLY

☐Transplant & Research ☐ Transplant ONLY ☐ Research Only

Tissue Recovered by other Agency: ☐ No ☐ Yes If Yes: ☐ OPO ID#_____ ☐ UMTB ID#_____

4.0 CAUSE OF DEATH DETERMINATION

4.1 Manner of Death:_____

Cause of Death:_____

COD Source (ME log, pathologist's name, medical record, etc.):_____

Recorded by/Date/Time:_____

4.2 Is this an ME Case?: ☐ No ☐ Yes: ME #_____ Is an Autopsy being performed?: ☐ No ☐ Yes

If no to both questions: N/A 4.2 and 4.3

Type of examination: ☐ External Examination ☐ Autopsy

☐ Autopsy pathologist name: _____ Agency _____ Date_____

☐ Ext Examination pathologist name:_____ Agency _____ Date_____

Height per examining agency _____ft/inch or cm Weight per examining agency _____lb or kg

Any evidence of high risk behavior or communicable disease that would preclude the use of this tissue for surgical use found during either external examination or autopsy? ☐ No ☐ Yes

If Yes, Describe_____

4.3 *Cause of death as per final report:* _____

Report reviewed and recorded by (initials): _____Date: _____

5.0 DONOR PHYSICAL ASSESSMENT as per *SOP-04-006 Donor Physical Assessment procedure*

If part of the physical assessment cannot be performed for any reason, you MUST record this situation under the comment section and contact the administrator on call (AOC) for further instructions. Place other agencies physical assessment in the donor's chart as applicable.

5.1 Nutritional State: ☐ Cachexic ☐ Normal ☐ Overweight ☐ Obese

5.2 Cleanliness: ☐ Good ☐ Poor (Describe) _____

5.3 Oral Cavity: Any evidence of oral thrush ☐No ☐Unable to Visualize (describe) ☐Yes Describe):

_____

5.4 Males: ☐ N/A

5.4.1 Any signs of sexual aberration (eg. sex change, use of female attire, color enamel on nails, etc.)?
☐ No ☐ Yes If yes (describe):_____

5.4.2 Any physical evidence of insertion trauma and/or anal intercourse including perianal condyloma.
☐ No ☐ Yes If yes (describe):_____

5.5 Head:

5.5.1 Any obvious abnormality: ☐ No ☐ Yes (describe): _____

5.5.2 Trauma (lacerations, contusions, loss of tissue, etc.): ☐ No ☐ Yes (describe):

_____

5.6 Eyes:

5.6.1 External eye examination: (includes eye lids, periorbital area, eyebrows, eyelashes, etc.):
Normal ☐ OD ☐OS Edema ☐ OD ☐OS Trauma ☐ OD ☐OS
Other ☐ OD ☐OS (describe): _____

5.7 Penlight examination:

5.7.1	Cornea: Normal	☐ OD	☐OS	Abnormal	☐ OD	☐OS	Arcus	☐ OD ☐OS
5.7.2	Lens: Phakic	☐ OD	☐OS	Aphakic	☐ OD	☐OS	IOL	☐ OD ☐OS
5.7.3	Sclera: Normal	☐ OD	☐OS	Jaundice	☐ OD	☐OS	Abnormal	☐ OD ☐OS
5.7.4	Other: (includes conjunctiva, iris, lacrimal sac):			Normal	☐ OD	☐OS	Abnormal	☐ OD ☐OS

Comments: _____

5.8 Skin:

5.8.1 General Hydration Aspect:
☐ Normal (well-hydrated) ☐ Dry (dehydrated) ☐ Edema (over hydrated): ☐ Generalized (entire body) ☐ Localized (where?)_____

5.8.2 Color (tint): ☐ Normal ☐ Abnormal: ☐ Generalized (entire body) ☐ Localized (where?):_____

5.8.3 Questionable marks: (Sites most likely to be found: face, ears, nose, nasal septum, lips, tongue, chest, nipples, abdomen, navel, thighs, ankles, pubic area, external genitalia, buttocks, perianal, arms, wrist, fingers, knuckles, toes, toe webs, back of legs):

(1) Non-medical injection sites ☐ No ☐ Yes (describe location): _____

(2) Scab or lesion consistent with recent smallpox immunization: ☐ No ☐ Yes (describe location):

_____

(3) Tattoos: ☐ No ☐ Yes Looks: (☐old ☐ fresh ☐ non- professional ☐ professionally done) Look for hidden needle tracks.

Describe and record location): _____

(4) Acupuncture and / or Body piercing: ☐ No ☐ Yes (☐old ☐ fresh Describe and record location):

_____

5.9 Any evidence of sexually transmitted disease (chancre, genital ulcer, rash on the palms and soles of feet, venereal warts, blue or purple spots consistent with Kaposi's sarcoma): ☐ No ☐ Yes (describe and location):

_____

5.10 Any of the following evidence of disease or infection: (Generalized rash, multiple bruising, suspicious moles (nevus), exudates, inflammation, generalized jaundice), other: ☐ No ☐ Yes (describe and location):

_____

5.11 Lymphadenopathy (enlarged lymph nodes; most likely body areas: neck, supraclavicular, axillary and inguinal (groin):

☐ No ☐ Yes (describe and location): _____

5.12 Donor's body was observed front and back and findings were recorded? ☐ Yes ☐ No (if no contact AOC and explain):_____

5.13 Donor physical assessment performed on (Date/Time): _____/_____

Comments:_____

_____

6.0 TISSUE RECOVERY

Note: Perform the surgical scrub as per *SOP-04-009 Surgical Hand Wash-Rub Procedure. Perform recovery as per SOP-04-008 Aseptic Preparation of Field and Donor and SOP-04-016 In Situ Tissue Recovery respectively.*

6.1 Apply the Betadine as per procedure (3-5 min) start time:_____ end time:_____

6.2 Type of procedure performed:

☐ Enucleation (Preserved in Moist Chamber): ☐ OD ☐ OS ☐ Corneal Excision (Preserved in Optisol-GS): ☐ OD ☐ OS

Date/Time of Recovery:_____/_____

6.3 Blood sample drawn by: ☐ FLEB ☐LAORA ☐UMTB ☐HOSPITAL_____☐M.E_____

☐ Pre mortem ☐ Post mortem Blood drawn on: Date/Time: _____/_____

Was blood sample centrifuged at recovery site? ☐ No ☐ Yes: Date/Time:_____/_____

Blood/serum refrigeration time: Date/Time:_____/_____

6.0 REAGENTS & SUPPLIES:

Record lot numbers and expiration dates below for all reagents and sterile supplies used for recovery and ***verify that all reagents and supplies are sealed, not damage, not expired and are acceptable for use.***

A. Sterilized Instruments Load # _____

B. OD Optisol-GS Lot#_____ Exp._____

C. OS Optisol-GS Lot#_____ Exp._____

D. Polymyxin B Sulfate & Trimethoprim Lot#_____ Exp._____

E. Betadine 5% Solution Lot#_____ Exp._____

F. Sterile BSS Lot#_____ Exp._____

G. Disposable Scalpels Lot#_____ Exp._____

H. Ophthalmic Incise Sheet Lot#_____ Exp._____

I. Sterile Gloves Lot#_____ Exp._____

J. Sterile Sleeves Lot#_____ Exp._____

K. Blood Tubes (tiger top) Lot#_____ Exp._____

L. Sterile Needle (ocular fluid) Lot#_____ Exp._____

M. Syringe (ocular fluid) Lot#_____ Exp._____

N. Povidone Iodine swabs Lot#_____ Exp._____

O. Sterile Gauzes Lot#_____ Exp._____

P. Sterile Cotton Tip Applicator Lot#_____ Exp._____

Q. Sterile Specimen Cups Lot#_____ Exp._____

R. Alcohol Pads Lot#_____ Exp._____

S. Viewing Chambers Lot#_____ Exp._____

T. Sterile Field Drapes Lot#_____ Exp._____

U. Other_____ Lot#_____ Exp._____

V. Place sterilization load labels here

7.0 TECHNICIAN'S PROCESS CERTIFICATION

Additional Comments: _____

_____

I certify that this process was performed according to approved procedures and that aseptic technique was observed at required times.

Signed by: _____ Date: _____