Maine Medical Center
MaineHealth

Patient Name: _____

MRN: _____

PRE-TRANSPLANT Verification Prior to Organ Receipt

To be filled out by SURGEON in OR		To be filled out by REGISTERED NURSE in OR
DONOR		**DONOR**
Expected donor ID: _____		Expected donor ID: _____
Expected organ: **Kidney** Laterality (circle correct): **Left** **Right**		Expected organ: **Kidney** Laterality (circle correct): **Left** **Right**
Expected donor blood type (circle correct type): **A** **B** **O** **AB** Subtype (if used for allocation): _____		Expected donor blood type (circle correct type): **A** **B** **O** **AB** Subtype (if used for allocation): _____
RECIPIENT		**RECIPIENT**
Recipient unique identifier: _____		Recipient unique identifier: _____
Recipient blood type (circle correct type): **A** **B** **O** **AB**		Recipient blood type (circle correct type): **A** **B** **O** **AB**
I have reviewed and verified the above listed information and confirm (check one): ☐ Expected donor and recipient are blood type compatible, **OR** ☐ Expected donor and recipient have an intended incompatibility		I have reviewed and verified the above listed information and confirm (check one): ☐ Expected donor and recipient are blood type compatible, **OR** ☐ Expected donor and recipient have an intended incompatibility
Transplant Surgeon signature: _____ Verification completed date: _____ Verification completed time: _____		RN signature: _____ Verification completed date: _____ Verification completed time: _____

EVENT TIMES:

Patient in room date/time: _____

Organ in room date/time: _____

Anesthesia induction date/time: _____

Initial incision date/time: _____

The pre-transplant verification prior to organ receipt was completed according to the hospital's protocol and OPTN/UNOS requirements.