Maine Medical Center
MaineHealth

Patient Name: _____

MRN: _____

LIVING DONOR Pre-Recovery Verification

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

EVENT TIMES:

Anesthesia induction date/time: _____

The living donor pre-recovery verification was completed according to the hospital's protocol and OPTN/UNOS requirements.