LiveOnNY

Tissue Referral Worksheet

all cardiac deaths must be called in to LiveOnNY within one hour of death without exception
1-800-GIFT-4-NY (1-800-443-8469)

Demographics

Hospital _____ Unit _____ Unit Phone _____

Patient Name _____ Gender _____ Race _____

Medical Record # _____ Height _____ Weight _____

Admit Date/Time _____ DOB _____ Admitting Dx _____

Death Date/Time _____ Vent Status _____ Cause of Death _____

Comorbidities

HIV _____ Hep B/C _____ Leukemia _____

Lymphoma _____ Cancer _____ Pos Blood Cultures _____
(within 48 hrs of TOD)

Hospital Course

Medical History _____
Current Meds _____

Circumstances of Event, EMS or ACLS Protocol _____
Chest X-Ray Results _____ Last Known Alive Time _____

Below for three days preceding cardiac arrest (if available)

WBC Count _____ Temperature _____
_____ _____
_____ _____

Blood Culture _____ Urine Culture _____ Sputum Culture _____
_____ _____ _____
_____ _____ _____

Hospital/Family Information

Medical Examiner # _____ Primary Doctor _____
(if involved) _____ Attending _____
Hospital Autopsy? _____ Pronouncing _____

Patient Address _____
Next of Kin Name _____
Family Phone/Address _____

(If Available)

Morgue Time _____
Family Notified? _____ Funeral Home Name/Phone _____

LiveOnNY to follow / ruled out
(circle one)

This is not part of the
permanent medical record.
Please discard after referring to LiveOnNY.

Referral Time _____
LiveOnNY Case # _____