SUNY DOWNSTATE MEDICAL CENTER
TRANSPLANT SURGERY LIVING DONOR
ABO / SITE VERIFICATION FORM

PATIENT NAME_____
MEDICAL RECORD #_____
DOB_____ SEX_____NS_____
PHYSICIAN_____

Section I To be completed prior to the induction of anesthesia. Section 2 to be completed immediately prior to cross clamp.

Section I(a). Pre-Anesthesia Induction

DONOR:

❒ Donor UNOS ID:_____
Donor Organ: Kidney: ❒ Right ❒ Left
❒ Expected Donor Blood Type: _____

Donor ABO Compatible for Correct Recipient:
❒ Yes ❒ No ❒ Intended Incompatible

❒ Correct Donor for Correct Recipient: ❒ Yes

RECIPIENT:

❒ Recipient MRN:_____

❒ Recipient Blood Type: _____

Section I (b). Verification of ABO Status (Donor / Recipient) Pre-anesthesia Induction

Recipient	❒ O	❒ A	❒ B	❒ AB
Donor	❒ O	❒ A	❒ B	❒ AB
		❒ A1	❒ O	❒ O
		❒ O	❒ A_2	❒ A1B
			❒ A_2B	❒ A
				❒ B

Section I (c). Provider Confirmation Pre- Induction

Attending Transplant Surgeon:
Print Name:_____ Signature:_____ Date:_____ Time:_____

Circulating Nurse:
Print Name:_____ Signature:_____ Date:_____ Time: _____

Section II (a). Verification Prior to Organ Leaving theDonor Room

Living Donor UNOS ID:_____
Recipient MRN: _____
❒ Laterality ❒ Right ❒ Left

Recipient Blood Type	❒ O	❒ A	❒ B	❒ AB
Donor Blood Type	❒ O	❒ A	❒ B	❒ AB
		❒ A1	❒ O	❒ O
		❒ O	❒ A_2	❒ A1B
			❒ A_2B	❒ A
				❒ B

❒ Correct Donor for Correct Recipient: ❒ Yes
Cross Clamp Time: _____

Section II (b). Provider Confirmation Prior to Cross Clamp and Removal of Organ

Attending Transplant Surgeon:
Print Name: _____ Signature:_____ Date:_____ Time:_____

Circulating Nurse:
Print Name:_____ Signature:_____ Date:_____ Time: _____

❒ I completed the Verification in Real Time