Iowa Donor Network Referral Information

1-800-831-4131

This form serves as a reference guide for common questions asked when making a referral call to Iowa Donor Network. There may be additional questions.

AGENCY INFORMATION:

Your name, title, hospital name, phone number, and scene location

PATIENT INFORMATION AND PAST MEDICAL HISTORY:

Patient Name: _____ DOB:_____ Age: _____ Gender: _____

Height: _____ Weight: _____ Race: _____

Cause of death: _____ Date of death: _____ Time of death: _____

Last time known alive (out of hospital or not witnessed): _____

Clinical course/circumstances surrounding death: _____

_____

EMS Interventions: _____

_____

Condition of the body: _____

History of: HIV: _____ Hepatitis B: _____ Hepatitis C: _____

Cancer: _____ Type: _____ When: _____ Chemo: _____ Radiation: _____

Alzheimer's: Yes _____ No _____ OR medications used to treat Alzheimer's: Aricept/Donepezil; Rivastigmine/Exelon; Galantamine/Razadyne; Tacrine/Cognex; Namenda

IV fluids/IV meds given in the hour prior to death: Yes _____ Amount: _____mls

How many IV/IO attempts: _____ Where: _____

Past Medical History: _____

_____

Medications: _____

ADDITIONAL INFORMATION:

Family, Next of Kin or Durable Power of Attorney:

Name: _____ Relationship: _____ Number: _____

Medical Examiner case: Yes _____ No _____ Name of ME: _____

Contact Number: _____ Autopsy: Yes _____ No _____

Funeral Home name: _____ Number: _____