



# Iowa Donor Network Notification Information

## 1-800-831-4131

This form serves as a reference guide for common questions asked when notifying Iowa Donor Network of a death.  
There may be additional questions.

### HOSPITAL INFORMATION:

Your name, title, hospital name, phone number, and unit details

### PATIENT INFORMATION (all notification calls):

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ MRN: \_\_\_\_\_ Race: \_\_\_\_\_

Admission date: \_\_\_\_\_ Time: \_\_\_\_\_ Admission diagnosis: \_\_\_\_\_

If transported by EMS, name of EMS service: \_\_\_\_\_ Cause of death: \_\_\_\_\_

Date of death: \_\_\_\_\_ Time of death: \_\_\_\_\_

Last time known alive (if applicable): \_\_\_\_\_

### IF IDN DOES NOT HAVE EMR ACCESS FOR YOUR HOSPITAL OR IF EMR IS NOT UPDATED:

Clinical course/circumstances surrounding death: \_\_\_\_\_

History of: HIV: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_ Hepatitis C: \_\_\_\_\_

Cancer: \_\_\_\_\_ Type: \_\_\_\_\_ When: \_\_\_\_\_ Chemo: \_\_\_\_\_ Radiation: \_\_\_\_\_

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

Signs/symptoms of systemic infection: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, signs include: \_\_\_\_\_

IV fluids/IV meds given in the hour prior to death: Yes \_\_\_\_\_ Amount: \_\_\_\_\_ mls

Blood/blood products/colloids/TPN given in the last 48 hours: Yes \_\_\_\_\_ Amount: \_\_\_\_\_ mls

Past Medical History: \_\_\_\_\_

Medications: \_\_\_\_\_

Antibiotics given: Yes \_\_\_\_\_ No \_\_\_\_\_ Date started: \_\_\_\_\_ Date stopped: \_\_\_\_\_

WBC (past 3 days if available):

1. Date: \_\_\_\_\_ WBC: \_\_\_\_\_ Temp: \_\_\_\_\_

2. Date: \_\_\_\_\_ WBC: \_\_\_\_\_ Temp: \_\_\_\_\_

3. Date: \_\_\_\_\_ WBC: \_\_\_\_\_ Temp: \_\_\_\_\_

MRSA: Yes \_\_\_\_\_ No \_\_\_\_\_ VRE: Yes \_\_\_\_\_ No \_\_\_\_\_ C-Diff: Yes \_\_\_\_\_ No \_\_\_\_\_ Isolation: Yes \_\_\_\_\_ No \_\_\_\_\_ CXR: Yes \_\_\_\_\_ No \_\_\_\_\_

Blood cultures: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Result: \_\_\_\_\_

### ADDITIONAL INFORMATION:

#### Family, Next of Kin or Durable Power of Attorney:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Examiner case: Yes \_\_\_\_\_ No \_\_\_\_\_ Name of ME: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Autopsy: Yes \_\_\_\_\_ No \_\_\_\_\_

Funeral Home name: \_\_\_\_\_ Number: \_\_\_\_\_