

**FRM6439/7 SARS-CoV-2 Assessment and Screening  
(in deceased organ donors)**



**Blood and Transplant**  
Effective date: 30/03/2022

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Completion of this form is mandatory for ALL donors as part of the donor characterisation process and must be made available to transplant centres and laboratories, as appropriate.

	Question	Comments/Details
1	Name, DOB, Unit Name	
2	Date and reason for admission to hospital	
3	Date and time of admission to ICU	
4	Location on admission and subsequent movement in ICU (i.e. side room, open bay)	
5	Chest X Ray/CT Please ensure the Chest X ray/CT is reviewed by the ICU medical team  Any abnormalities to the Chest X ray/CT? Yes      No      (please give details)  Give relevant details in case of changes	
<b>Previous SARS-Cov-2 Infection or Known Exposure to SARS-CoV-2</b>		
6	Any history/previous diagnosis of SARS-Cov-2 infection?  Yes                      No	Symptoms:  Date of onset of symptoms:
7	In relation to Q6, was SARS-Cov-2 infection confirmed on RNA testing?  Yes                      No                      N/A	Date of Diagnosis (date of first positive SARS-CoV-2 RNA):  Please also enter available information on table in Q16
8	Did this result in a hospital admission?  Yes                      No                      N/A	Date of hospital admission:  Date of discharge:

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9	Please confirm resolution of COVID-19 symptoms including no fever for at least 48 hours (resolving cough and anosmia are acceptable as these may remain for several weeks)	Yes                      No                      N/A If 'No' please specify:
10	Any exposure to a proven case of COVID-19 in the last 10 days?  Yes                      No (check that this was a definitive exposure to someone who was infectious* at the time)  <i>*Generally defined as from 48 hours before to around 7-10 days after date of onset of symptoms*</i>	Date of exposure:  Nature of exposure:  When did the index case test positive?
11	Other SARS-CoV-2 positive patients in the unit?:  Consider Infection, Prevention and Control measures.  Include information such as any specific concerns, date of admission and testing undertaken as appropriate.  <i>Do NOT record Patient ID Detail (confidentiality)</i>	Yes                      No If 'Yes' please specify:
12	Please confirm the ICU team feel COVID-19 has been reasonably excluded (history, exam tests, radiology).	Yes                      No  Any other relevant information, please add to section 15

**\*\*\*If there is a strong clinical suspicion of current COVID-19 as determined by ICU team, then donation should NOT proceed**

Vaccination History		
13	Has COVID-19 vaccine been given?  Yes                      No	1st dose date: Type:  2nd dose date: Type:  3rd dose date: Type:  4th dose date: Type:
14	If the donor has had an intracranial disaster and also has low platelets, haematology advice may be needed.	
	Are the intensive care physicians satisfied that Vaccine-induced Thrombosis and Thrombocytopenia (VITT) has been reasonably excluded in this donor, where appropriate?	Yes                      No

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**Any additional information**

15	Any other relevant information?
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**SARS-CoV-2 RNA Results**

16	Summary of SARS-CoV-2 RNA results available to donation team (including pre-admission results). <b>These <u>MUST</u> be recorded in <u>chronological order</u>.</b>
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Date and Time Taken DD/MM/YY 00:00	Sample Type (NTS/NPA/ETA)	Indication for Testing	Details of test results	
			Assay name and cycle threshold (Ct) value where available (get lab assistance to complete)	Result

In cases where there is suspicion of exposure to SARS-CoV-2 or positive/borderline SARS-CoV-2 RNA results virologists are asked to provide a clinical interpretation based on information provided in this form. Written interpretation should be provided. For Northern Ireland via Belfast Trust Links Labs system, for all other virology laboratories via secure email. Please ensure the interpretation include 3 points of PID including donor ID

Failure of internal control amplification invalidates the test – no result available (system failure). The test needs to be repeated on the same or another sample. This is not an indeterminate result.

**Virologists and transplant teams requiring further information should contact SN as shown below.**

**Completed by**

Name: Specialist Nurse

Contact number / team pager:

Email: