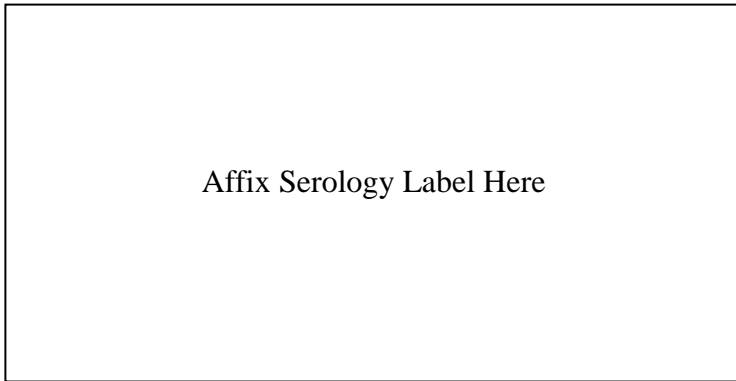


**CENTER FOR ORGAN RECOVERY & EDUCATION
VESSEL DONOR FORM**

Donor Name: _____ UNOS ID#: _____
Date of Birth: _____ Cause of Death: _____
Hospital: _____ City: _____ State: _____
Date of Recovery: _____ Cross Clamp Time: _____ AM/PM (EST)
Blood Type: _____ Vessel Exp. Date/Time (14 days): _____ / _____ AM/PM

(Circle Vessel Type):

Iliac Vein-Liver Iliac Vein-Panc Carotid Artery
Iliac Artery-Liver Iliac Artery-Panc Mesenteric Artery Aorta



Comments:

I personally have verified this donor information to be correct.

Coordinator: _____

Name Printed: _____

Please place completed form in plastic sleeve provided on vessel storage container for delivery to recipient hospital. The opposite side is to be completed by the recipient surgeon.

800-366-6777

**CENTER FOR ORGAN RECOVERY & EDUCATION
VESSEL RECIPIENT FORM**

Recipient Name: _____
Recipient ABO: _____
Recipient Hospital: _____
Recipient Blood Type: _____
Organ Transplanted: _____

Circle Vessel Transplanted:

Iliac Vein-Liver Iliac Vein-Panc Carotid Artery
Iliac Artery-Liver Iliac Artery-Panc Mesenteric Artery Aorta

Partial _____ Whole _____

Transplant Date: _____ Time: _____ AM/PM

Comments:

I personally have reviewed the donor information provided. I understand that CORE does not warranty any organs or tissue provided.

I personally have verified this recipient information to be correct.

Surgeon's Signature: _____

Name Printed: _____

Please place completed form in envelope provided for pickup by the
Center for Organ Recovery & Education

CORE Form R-39 (11/04, 10/05, 01/08, 01/01/10, 09/08/10, 8/6/13)

800-366-6777
FAX 412-963-3563