Pre–Brain Stem Death Certification Clinical Information Form

Name of the hospital:

Treating doctor: Name of the ICU:

Tentative date & time for Brain-stem death testing:

Name of the patient: Age: Sex:

Blood group: MLC: YES/NO

Cause of suspected brain stem death:

Neuroimaging evidence of CNS Catastrophe: YES/NO

Date and time of admission at current institution:

Date and time of initiating ventilator support:

GCS on admission: Current GCS:

Supportive medications if any with current dose:

BP: Core body temperature: Blood glucose:

Sodium: Potassium:

History of intoxication, ingestion/administration of depressant and/or muscle relaxants has been reviewed carefully: YES/NO

Other comorbidities and duration (in years) since diagnosis:

Contact number of concerned doctor/ICU:

K-SOTTO