Adult Brain Death Assessment

Patient Progress Notes

Note:

1. **Clinical assessment must be performed by two physicians, one of whom must be a critical care specialist or neurospecialist (check your hospital's policy.)**
2. **Either physician A or B must be a licensed physician; not necessarily a specialist.**
3. **Brain death certification constitutes pronouncement of death, and is a medical act. Ventilator support will be withdrawn, unless organ donation is considered.**

	Protocol for Certification of Brain Death	Dr. A	Dr. B
1.	Date and time of exam	Date: Time:	Date: Time:
2.	Physician's Name *please print→*		
3.	**Preconditions:**		
(A)	Is the cause of brain damage known?	❑ Yes ❑ No	❑ Yes ❑ No
(B)	Have CNS depressant drugs been excluded? (ethanol, barbiturates, benzodiazepines, muscle relaxants) Toxicology screen (if indicated)— theraputic levels are not a contraindication.	❑ Yes ❑ No	❑ Yes ❑ No
(C)	**Record body temperature** (must be >32°C or 90°F)		
(D)	Are endocrine causes excluded?	❑ Yes ❑ No	❑ Yes ❑ No
4.	**Clinical Assessment**		
(A)	Both pupils fixed to light	❑ Yes ❑ No	❑ Yes ❑ No
(B)	No response to intense central pain	❑ Yes ❑ No	❑ Yes ❑ No
(C)	Absent corneal/lash reflexes	❑ Yes ❑ No	❑ Yes ❑ No
(D)	Absent cough/gag reflex	❑ Yes ❑ No	❑ Yes ❑ No
(E)	Absent oculocephalic response or	❑ Yes ❑ No	❑ Yes ❑ No
(F)	Absent ice-water ocular caloric response each ear	❑ Yes ❑ No	❑ Yes ❑ No
5.	**Apnea Documented**		
(A)	Respiratory reflex is absent to apnea testing		❑ Yes ❑ No

6. Optional Tests (only required if unable to perform apnea test)

1. EEG is isoelectric? ❑ Yes ❑ No
2. Absent cerebral blood flow? ❑ Yes ❑ No

CERTIFICATION

On the basis of the findings recorded above, indicating irreversible loss of function of the entire brain, including the brain stem, we hereby certify the death of:

Patient's Name: _____ **Date:**_____ **Time of Death:**_____

Physician Signature A: _____ **Date & Time:** _____

Physician Signature B: _____ **Date & Time:** _____

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