BPV Case ID: _____ Affix BPV Case ID Label Tissue Bank ID:_____	Form Completed By: _____ Date Form Was Completed: __ __/__ __/__ __ __ __ MM/DD/YYYY

Pre-operative Medications Administration (Record medications administered in the holding area prior to patient entering the operating room. If additional space is required, record any additional pre-operative medications administered in #6 below.)				
1	**Date of Surgery**	__ __/__ __/__ __ __ __ MM/DD/YYYY		
2	**Pre-operative IV Sedation Administered**	O Yes O No		
		☐ Diazepam	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Lorazepam	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Midazolam	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other IV Sedation (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID:** _____
Form Completed By: _____	**Date Completed:** __ __ /__ __ /__ __ __ __ **MM/DD/YYYY**

3	**Pre-operative IV Opiates Administered**	O Yes O No		
		☐ Fentanyl	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Hydromorphone	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Meperidine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Morphine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other IV Opiates (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
4	**Pre-operative IV Antiemetics Administered**	O Yes O No		
		☐ Droperidol	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Ondansetron	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other IV Antiemetic (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID:** _____
Form Completed By: _____	**Date Completed:** __ __ /__ __ /__ __ __ __ **MM/DD/YYYY**

5	**Pre-operative IV Anti-acids Administered**	O Yes O No		
		☐ Ranitidine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Other Anti-acid (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
6	**Other Pre-operative IV Medications Administered**	O Yes O No		
		☐ Other Pre-op Medication (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Record additional IV medications administered pre-operatively, if applicable.
		☐ Other Pre-op Medication (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other Pre-op Medication (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

Type of Anesthesia Administered (PLEASE RECORD ONLY ANESTHESIA AGENTS ADMINISTERED PRIOR TO REMOVAL OF THE ORGAN. If additional space is required record any additional anesthesia agents administered in #14 below.)

7	**Local Anesthesia Agents Administered**	O Yes O No		
		☐ Lidocaine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Procaine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other Local Anesthetic (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
8	**Regional (Spinal/Epidural) Anesthesia Agents Administered**	O Yes O No		
		☐ Bupivacaine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Lidocaine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other Spinal/Regional Anesthetic (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID:** _____
Form Completed By: _____	**Date Completed:** __ __ /__ __ /__ __ __ __ **MM/DD/YYYY**

9	**IV Anesthesia Agents Administered**	O Yes O No		
		☐ Brevital	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Etomidate	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Ketamine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Propofol	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Sodium Thiopental	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other IV Anesthesia Agents (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID:** _____
Form Completed By: _____	**Date Completed:** __ __ /__ __ /__ __ __ __ **MM/DD/YYYY**

10	**IV Narcotic/Opiate Agents Administered**	O Yes O No		
		☐ Fentanyl	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Hydromorphone	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Meperidine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Morphine	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other Narcotics/Opiates (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
11	**IV Muscle Relaxants Administered**	O Yes O No		
		☐ Pancuronium	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply. **Please use the supplemental page at the end of this form when more than one dose/time is administered.**
		☐ Suxamethonium Chloride	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Vercuronium	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other Muscle Relaxants	Dose: _____ Unit: _____	

BPV Case ID: _____	**Tissue Bank ID:** _____
Form Completed By: _____	**Date Completed:** __ __ /__ __ /__ __ __ __ **MM/DD/YYYY**

		(specify)	Time: __ __ : __ __ (HH:MM)	

12	**Inhalation Anesthesia Agents Administered**	O Yes O No		
		☐ Isoflurane	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Select all that apply.
		☐ Nitrous Oxide	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other Inhalation Anesthesia Agents (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
13	**Additional Anesthesia Agents Used**	O Yes O No		
		☐ Other (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	Record any additional anesthesia agents administered prior to removal of the organ.
		☐ Other (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		☐ Other (specify)	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

Surgery Information (Indicate whether any of the following medications were administered during surgery.)

14	**Other Medications Administered During Surgery Prior to Removal of the Organ**	Was insulin administered during surgery? O Yes O No If Yes, enter dose and time → ☐ Specify insulin:	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM) Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	**Please use the supplemental page at the end of this form if you require additional space.**
		Were steroids administered during surgery? O Yes O No If Yes, enter dose and time → ☐ Specify steroid(s):	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM) Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		Were antibiotics administered during surgery? O Yes O No If Yes, enter dose and time → ☐ Specify antibiotic(s):	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM) Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	
		Were other medications administered during surgery? O Yes O No If Yes, enter dose and time → ☐ Specify other medication(s):	Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM) Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

Surgical Procedure Details			
15	**Time of First Incision:**	__ __ : __ __ (HH:MM)	
16	**Surgical Procedure**	Select One: O Lung biopsy, left O Lung biopsy, right O Lung lobectory, left O Lung lobectomy, right O Lung mass excision, left O Lung mass excision, right O Pneumonectomy, left O Pneumonectomy, right O Wedge resection, left O Wedge resection, right O Other (specify) — **Specify other procedure:**	Surgical procedure performed.
17	**Time of First Clamp**	__ __ : __ __ (HH:MM)	Time first clamp was applied.
18	**Time of Second Clamp**	__ __ : __ __ (HH:MM)	Time second clamp was applied.
19	**Time of Organ Resection**	__ __ : __ __ (HH:MM)	Time organ was resected.
20	**In Vivo Intra-operative Ischemic Period (minutes)**	_____ (minutes)	Elapsed time from first application of first clamp to organ resection.

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

Patient's Vital Signs (PRIOR TO EXCISION OF ORGAN)				
21	**Describe BP Excursions from Time of Anesthesia Induction to 15 Minutes Post**			Note duration of variances of greater than 20 mmHg from patient's pre-operative baseline during first 15 minutes after anesthesia induction.
22	**Describe BP Excursions from 15 Minutes Post-anesthesia Induction to Organ Excision**			Note duration of variances of greater than 20 mmHg from patient's pre-operative baseline from 15 minutes post anesthesia induction to organ excision.
23	**Temperature**	First patient temperature recorded in OR _____ °F or °C (Circle temperature scale)	Time of first temperature __ __ : __ __ (HH:MM)	
		Second patient temperature recorded in OR _____ °F or °C (Circle temperature scale)	Time of second temperature __ __ : __ __ (HH:MM)	
24	**Describe Epochs of Oxygen (O_2) Desaturation of <92% for >5 Minutes Prior to Organ Excision**			

BPV Case ID: _____	Tissue Bank ID: _____
Form Completed By: _____	Date Completed: __ __ /__ __ /__ __ __ __ MM/DD/YYYY

25	**Carbon Dioxide Level (CO_2) Recorded at Time Closest to Organ Excision**			
Intra-operative Blood Product Administration				
26a	**Albumin**	_____ (ml)		
26b	**Packed Red Blood Cells**	_____ (# units)		
26c	**Platelets**	_____ (ml)		
26d	**Fresh Frozen Plasma**	_____ (# units)		
Patient Fluid Output				
27	**Blood Loss**	_____ (ml)	**At what point was blood loss recorded?** Select One: O Prior to organ excision O End of surgery	Intra-operative blood loss.
Fluid Loss				
28	**Urine Volume Excreted**	_____ (ml)	**At what point was urine output recorded?** Select One: O Prior to organ excision O End of surgery	Urine volume excreted.
29	**Was Ascites Fluid Collected?**	Select one: O Yes O No	_____ (ml)	
Additional Information:				
30	**Duration of Fasting Prior to Surgery**	_____ (hours)		

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

31	**Describe Pre-operative Bowel Preparation Prior to Surgery**		
32	**Other Notable Events During Surgery**		Unusual events or extreme variations from usual procedure.
33	**Time Specimen Left OR**	__ __ : __ __ (HH:MM)	

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

Supplemental Medication Administration		
Additional Pre-operative Medications Administered	**Medication**	**Dose and Time**
Notes:		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

Additional Anesthesia Agents Administered	**Anesthesia Agents**	**Dose and Time**
Notes:		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)

BPV Case ID: _____	**Tissue Bank ID: _____**
Form Completed By: _____	**Date Completed: __ __ /__ __ /__ __ __ __** **MM/DD/YYYY**

Additional Intra-operative Medications Administered	Medications	Date and Time
Notes:		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)
		Dose: _____ Unit: _____ Time: __ __ : __ __ (HH:MM)