

**BRAIN DEATH DECLARATION
(TO BE COMPLETED BY DECLARING PHYSICIAN)**

Patient's Name: _____

Clinical neurologic exam to determine irreversible loss of brain and brain stem function:

(Please checkmark all that apply)

- Irreversible Coma – Etiology: _____
- Absence of oculocephalic and/or oculovestibular (dolls eyes) reflexes
- Absence of pupillary reflexes – direct or consensual
- Absence of corneal reflexes
- Absence of cough/gag on tracheal suction
- Absence of spontaneous movements and no response to central painful stimulation (spinal cord reflexes may be present)
- Absence of possible reversible cause of brain activity. (Temperature must be greater than 36 degrees Celsius (96.8 degrees Fahrenheit), no sedative/paralytic drugs. No significant drug intoxication or poisoning, no severe electrolyte, acid-base or endocrine disturbance)

Apnea Test Performed: Time initiated: _____ Time Completed: _____

Beginning PaCO₂: _____ Ending PaCO₂: _____

Beginning pH: _____ Ending pH: _____

Unable to perform Apnea:

Reason: _____

Other Confirmatory Testing (Optional):

Modality: _____

Results: _____

Declaration of Brain Death:

_____ (patient's name) is declared brain dead by brain death criteria at _____ (time) on _____ (date).

By virtue of this signature, I have performed the above listed testing.

Physician Signature: _____ **Date:** _____ **Time:** _____

Printed Name of Physician: _____

**Please refer to your hospital's policy for Brain Death Declaration*

Affix Patient Label Here