



Neurocritical
Care Society

BRAIN DEATH

Sample Brain Death Policy Checklist

UNIT NO.:

NAME:

BIRTH DATE:

VISIT NUMBER:

(If handwritten, record name, unit no., birth date, and visit no.)

If the clinical examination cannot be performed adequately and an ancillary test is necessary, two examinations are NOT required.

<p>I. PREREQUISITES</p> <p>A. Clinical or neuroimaging evidence of acute CNS catastrophe that is compatible with irreversible loss of brain function</p> <p>B. Absence of complicating medical conditions</p> <p>1. Absence of severe electrolyte, acid base or endocrine disturbance or severe hyperammonemia</p> <p>2. Absence of drug intoxication, poisoning, sedatives or neuromuscular blocking agents</p> <p>3. Core temperature 96.8°F / 36°C or greater</p>	<p>I. FIRST EXAM</p> <p>A. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>3. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>I. SECOND EXAM</p> <p>A. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>3. Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>II. COMA or UNRESPONSIVENESS</p> <p>Absence of any cerebrally-mediated response to auditory and tactile noxious stimulation, peripherally and in the cranium</p>	<p>II. FIRST EXAM</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>II. SECOND EXAM</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>III. ABSENCE of BRAINSTEM REFLEXES</p> <p>A. Absent pupillary responses</p> <p>1. Pupillary size midposition or dilated</p> <p>2. Pupils unresponsive to bright light</p> <p>B. Absent eye movement</p> <p>1. Absent oculocephalic reflex</p> <p>2. Absent oculovestibular reflex (caloric responses) (N.B. The oculovestibular reflex must always be tested. The oculocephalic test may be contraindicated when C-spine integrity questioned; otherwise it must be tested.)</p> <p>C. Absent corneal reflexes</p> <p>D. Absent pharyngeal and tracheal reflexes</p> <p>1. Absent response to posterior pharyngeal stimulation</p> <p>2. Absent cough to bronchial suctioning</p> <p>3. Absent spontaneous respirations</p>	<p>III. FIRST EXAM</p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>C. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>3. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>III. SECOND EXAM</p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>C. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/></p> <p>3. Yes <input type="checkbox"/> No <input type="checkbox"/></p>



PT. NAME:

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IV. APNEA	IV. FIRST EXAM	IV. REPEAT APNEA TESTING IS NOT REQUIRED IF THE FIRST TEST CONFIRMS APNEA
A. Prerequisites		
1. Core temperature 96.8° F/ 36° C or greater	1. Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Systolic BP > 100 mmHg (with or without vasopressor agents)	2. Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Arterial pCO ₂ 40 +/- 5 mm Hg (in known non-CO ₂ retainer)	3. Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Arterial pO ₂ greater than 90 mm Hg	4. Yes <input type="checkbox"/> No <input type="checkbox"/>	
B. Apnea testing checklist		
1. Preoxygenate to a PaO ₂ >200 mm Hg and then administer 100% FIO ₂ during the entire test period	1. Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Disconnect the ventilator; monitor with pulse oximeter throughout the test period	2. Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Deliver 100% FIO ₂ into the trachea via a cannula at the level of the carina, maintaining oxygen saturation above 85%	3. Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Check arterial blood gases at 8-10 minutes and reconnect the ventilator when either a) pCO ₂ is 60 mmHg or greater, or b) pCO ₂ is greater than 20 mmHg above the patient's known baseline (in known CO ₂ retainers)	4. Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Abort the apnea test and immediately reconnect the ventilator for any of the following reasons:		
a. Systolic BP falls below 90 mm Hg or there is cardiovascular collapse	a. Yes <input type="checkbox"/> No <input type="checkbox"/>	
b. Oxygen desaturation (<85% for >30 seconds)	b. Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. Significant cardiac arrhythmia	c. Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. Respiratory movements are observed	d. Yes <input type="checkbox"/> No <input type="checkbox"/>	
C. RESULTS of APNEA TESTING		
1. APNEA CONFIRMED	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	OR	
2. APNEA TESTING CONTRAINDICATED	Yes <input type="checkbox"/>	
	OR	
3. APNEA TEST ABORTED	Yes <input type="checkbox"/>	

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I – IV MUST BE MET TO CONFIRM DEATH BY NEUROLOGICAL CRITERIA WITHOUT THE NEED FOR ANCILLARY TESTING**V. ANCILLARY TESTING IS REQUIRED WHEN ITEMS I AND II ARE MET BUT EITHER ITEM III (BRAINSTEM REFLEX TESTING) OR ITEM IV (APNEA TESTING) CANNOT BE COMPLETED OR CONFIDENTLY INTERPRETED****ANCILLARY Study Performed:**

- CONVENTIONAL CATHETER-BASED CEREBRAL ANGIOGRAPHY
- NUCLEAR MEDICINE CEREBRAL BLOOD FLOW STUDY (TECHNETIUM 99M SPECT)
- TRANSCRANIAL DOPPLER
- ELECTROENCEPHALOGRAPHY

DEMONSTRATED ABSENCE OF CEREBRAL BLOOD FLOW OR CEREBRAL ELECTRICAL ACTIVITY: YES NO **SUMMARY OF FINDINGS**

	YES	NO	OTHER
I. PREREQUISITES	<input type="checkbox"/>	<input type="checkbox"/>	
II. COMA or UNRESPONSIVENESS	<input type="checkbox"/>	<input type="checkbox"/>	
III. ABSENCE of BRAINSTEM REFLEXES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (Untestable)
IV. APNEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (Apnea test aborted or contraindicated)
V. BRAIN DEATH ESTABLISHED BY ANCILLARY TESTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (Not indicated)

CONFIRMED DEATH IN ADULTS BY Neurological CRITERIA YES NO 1st examiner signature: _____ / _____
Printed Name

Date: ____ / ____ / ____ Time: _____

2nd examiner signature: _____ / _____
Printed Name

Date: ____ / ____ / ____ Time: _____