APPENDIX 1

PROCEDURE FOR THE DIAGNOSIS AND CONFIRMATION OF CESSATION OF BRAIN-STEM FUNCTION BY NEUROLOGICAL TESTING OF BRAIN-STEM REFLEXES

Diagnosis is to be made by two doctors who have been registered for more than five years and are competent in the procedure. At least one should be a consultant. Testing should be undertaken by the doctors together and must always be performed completely and successfully on two occasions in total.

Patient Name: **Unit No:**

Pre-conditions

Are you satisfied that the patient suffers from a condition that has led to irreversible brain damage?

Specify the condition:

Dr A: **Dr B:**

Time of onset of unresponsive coma:

Dr A: **Dr B:**

Are you satisfied that potentially reversible causes for the patient's condition have been adequately excluded, in particular:

	DR A:	DR B:
DEPRESSANT DRUGS		
NEUROMUSCULAR BLOCKING DRUGS		
HYPOTHERMIA		
METABOLIC OR ENDOCRINE DISTURBANCES		

TESTS FOR ABSENCE OF BRAIN-STEM FUNCTION	1ST SET OF TESTS	2ND SET OF TESTS	1ST SET OF TESTS	2ND SET OF TESTS
DO THE PUPILS REACT TO LIGHT?				
ARE THERE CORNEAL REFLEXES?				
IS THERE EYE MOVEMENT ON CALORIC TESTING?				
ARE THERE MOTOR RESPONSES IN THE CRANIAL NERVE DISTRIBUTION IN RESPONSE TO STIMULATION OF FACE, LIMBS OR TRUNK?				
IS THE GAG REFLEX PRESENT?				
IS THERE A COUGH REFLEX?				
HAVE THE RECOMMENDATIONS CONCERNING TESTING FOR APNOEA BEEN FOLLOWED?				
WERE THERE ANY RESPIRATORY MOVEMENTS SEEN?				

Date and time of first set of tests:

Date and time of second set of tests:

Dr A Signature: **Dr B Signature:**

Status: **Status:`**