Brain Death Determination - Confirmation using Clinical Examination	**Results / Comments**
Mechanism consistent with brain death	
No other cause of coma, exclude the following:	
Toxins / drugs (no contributory abnormalities)	
Metabolic parameters (no contributory abnormalities)	
Vital signs	
Temperature (> 35 ^{o}C)	
Blood pressure normal for age	
Neurological Examination	
Response to verbal stimuli absent	
Pupils fixed	
Corneal reflex absent	
Oculocephalic reflex absent (test only if C-spine injury NOT suspected) Note: Omitting the oculocephalic test in the presence of c-spine injury is permitted as long as the oculovestibular reflex is tested and absent.	
Oculovestibular reflex absent	
Gag reflex absent	
Motor response to noxious stimulation absent	
Sucking/rooting reflexes absent (for infants)	
Apnea test ($pCO_2 \geq 60$ mmHg AND 20 mmHg above a baseline pCO_2 between 35-45) (Only one apnea test is required for adults $\geq$18 yrs if performed by an attending)	DATE: TIME: NAME OF PHYSICIAN WHO COMPLETED THE APNEA TEST:

☐ I certify that I have performed a complete clinical exam according to hospital policy and that this patient is brain dead.

OR

☐ I certify that I have performed a clinical examination as complete as circumstances permit and I have reviewed the results of the ancillary study indicated below, and that this person is brain dead. This will constitute an independent exam determining brain death only if confirmed by an ancillary test of cerebral blood flow or cerebral function noted below.

Print Name California licensed physician	**(Signature)**	**(c/e Number)**	**(date)**	**(time)**

Brain Death Approved Ancillary Tests	**Check Test Used below**
Diagnostic 4-vessel cerebral angiogram	
Radionuclide cerebral blood flow study	
EEG	

The dated and timed documentation of the independent confirmation of death by examination, will be the official pronouncement of death in the medical record.

(NAME, DOB, FIN, MRN)