When communicating with the donation staff, information likely to be required may include the following:

- name, date of birth and address;
- age, sex, weight and height;
- previous medical history — including comorbidities, surgery, malignancy, medication, alcohol consumption, smoking, illicit drug use and allergies;
- detailed history of current illness — including infection, cardiac arrest, hypotension or hypoxia;
- current clinical status — including level of ventilatory and inotropic support and physiological parameters;
- current investigations — full blood count, urea creatinine and electrolytes, liver function tests, coagulation profile, blood group, microbiology, ECG and Chest X-Ray; and
- whether donation will potentially occur after neurological or circulatory determination of death, and likelihood of death soon after withdrawal of physiologic supports (if DCDD).

It is important that communication with donation staff is not delayed simply to gather more comprehensive information as this can often be gathered at a later point.

The donation staff are responsible for taking blood for serologic testing and for tissue typing. These tests should only be carried out after the family agrees to donation, with the family understanding that the serology results may (uncommonly) indicate that donation is not possible. It may be appropriate for blood to be taken and transported but not tested until the family consents to donation.