



Dear potential donor,

Thank you for your interest in donating a kidney! Please fill out the entire kidney donor questionnaire and either FAX, EMAIL, or MAIL it to the Inova Transplant Center at the below contact information.

Please be aware of the following before completing the form.

- This is a confidential form and will only be shared with the kidney donor team
- You must fill out the form in entirety otherwise it will delay your evaluation
- If you are feeling pressured or coerced to be a donor in any way please contact the Living Donor Coordinator
- Please do not provide this form to others to fill out, if they are interested in becoming a donor please advise them to call and speak with our staff first
- The evaluation period will vary from donor to donor

Please note the following **contraindications** to kidney donation:

- Personal history of diabetes
- Personal history of significant high blood pressure requiring more than 1 medication to treat
- Personal history of malignancy (cancer) within the last 12 months
- Personal history of active kidney disease
- Please do not fill out this form and contact our coordinator if any of the above apply to you

Please send this form to:

Fax: 703-208-6654

Email: Kirsten.Greeley@inova.org

Mail: Attn: Kirsten Greeley

3300 Gallows Rd

Falls Church, VA 22042

Please feel free to contact the Living Donor Coordinator with any questions or concerns at 703-776-8053 or Kirsten.Greeley@inova.org

Name: _____

POTENTIAL KIDNEY LIVING DONOR MEDICAL HISTORY

This is a CONFIDENTIAL FORM. Please complete the entire form before submitting

Date: _____

Donor's legal name: _____

Recipient's name: _____

Relationship to the recipient: _____
(Please specify both relationship and if biological or non-biological)

Donor Personal Information

Date of birth: _____ Age: _____

Current Address (please include country if outside of the United States) _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Best phone number to contact you: _____

Social Security Number: _____ Sex: M F

Marital Status: _____ Race: _____ (Race is medically necessary)

Citizenship: US Citizen Permanent resident/Green card Other _____

Current Occupation: _____ Highest Level of Education: _____

Spouse's Name: _____ Spouse contact info: _____

Donor Health Information

Height: _____ Weight: _____

Do you currently have insurance? _____

Do you have a primary care physician? _____

Blood type _____

OFFICE USE ONLY

Recipient Dx: _____

Recipient # of txp: _____

DSA: _____

Serum Sample: _____

HD/PD: _____

Name: _____

Date of last Pap Smear: _____ Comment: _____

Date of last Mammogram: _____ Comment: _____

Date of last Colonoscopy: _____ Comment: _____

ALL WOMEN NEED TO PROVIDE A RECENT PAPSMEAR (WITHIN 2 YEARS) BEFORE DONATING
ALL WOMEN >44 NEED TO PROVIDE A RECENT MAMMO (WITHIN 2 YEARS) BEFORE DONATING
ALL PATIENTS >49 NEED TO PROVIDE A COPY OF A RECENT COLONOSOCOPY (WITHIN 10 YEARS) BEFORE
DONATING
ALL OF THESE TESTS ARE THE FINANCIAL RESPONSIBILITY OF THE DONOR

Have you ever smoked? Yes No

Cigarettes: _____(packs/amount per day) _____(number of years)_____ (quit date)

Cigars: _____(packs/amount per day) _____(number of years)_____ (quit date)

Pipe: _____(packs/amount per day) _____(number of years)_____ (quit date)

Chewing Tobacco: Snuff Chew (circle) _____(quit date)

Do you or have you used alcohol? Yes No

Type: _____

Amount: _____

Do you or have you used drugs? Yes No

Type: _____

Amount: _____

Please list any allergies: _____

Are you allergic to CT dye, shellfish, or iodine? (please specify) _____

Please list any current medications, vitamins, or herbal supplements you are taking (include dosage/frequency):

Name: _____

HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING	YES	NO	HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING	YES	NO
Abdominal Pain			Hepatitis		
Anemia			Herpes		
Anxiety			Hiatal Hernia		
Arthritis			High Blood Pressure		
Backache			Hormone Imbalance		
Bladder Infection			Hormone Supplements		
Bladder Problem			Impaired Hearing		
Bleeding Problems			Impaired Vision		
Blood Disorders			Irregular Heartbeat		
Blood in Urine			Kidney Biopsy		
Blood Transfusions			Kidney Infection		
Bruising			Kidney Stones		
Cancer			Leg Cramps		
Cataracts			Leg Pain		
Change in Bowel Habits			Liver Disease		
Chest Pain			Long Term Skin Disease		
Chronic Pain			Lung Disease		
Concussion			Lupus		
Congestive Heart Failure			Menstrual Complications		
Constipation			Night Time Urination		
Convulsions			Nose Bleeds		
Depression/Worry			Numbness		
Diabetes			Pacemaker		
Diabetes While Pregnant			Pregnancy		
Diarrhea			Prostate Difficulties		
Difficult Urination			Prostate Enlargement		
Dizziness/Vertigo			Rectal Bleeding		
Drug Addiction			Rheumatic Fever		
Ear Drainage			Sickle Cell Anemia		
Ear Ringing			Stroke		
Eating Disorders			Swelling		
Fainting Spells			Thyroid Imbalance		
Frequent Urination			Tuberculosis (TB)		
Glaucoma			Ulcers/Heartburn		
Gout			Urinary Tract Infection		
Headaches			Vomited Blood		
Heart Attack			Weight Change in the Last 6 Months		
Heart Disease			LIST OTHER:		
Heart Murmur					
Hemorrhoids					

Name: _____

If you answered yes to any of the medical conditions listed, please describe your illness including how many times you were treated and/or how long you were ill:

Have you ever had surgery? Yes No
If yes, please describe and provide dates:

FAMILY MEDICAL HISTORY

If you were adopted and your biological family history is unknown please check the following box and skip this section:

Has your mother passed away? _____ If yes, at what age? _____ What was the cause of death? _____

Has your father passed away? _____ If yes, at what age? _____ What was the cause of death? _____

Have any of your family members suffered from Kidney Disease? (please list which family members) _____

Mother (please check): Diabetes High Blood Pressure Heart Attack Heart Disease
High Cholesterol

Father (please check): Diabetes High Blood Pressure Heart Attack Heart Disease
High Cholesterol

Brother (please check): Diabetes High Blood Pressure Heart Attack Heart Disease
High Cholesterol

Sister (please check): Diabetes High Blood Pressure Heart Attack Heart Disease
High Cholesterol

Children (please check): Diabetes High Blood Pressure Heart Attack Heart Disease
High Cholesterol

How many brothers do you have? _____
How many sisters do you have? _____
How many children do you have? _____

Name: _____

Please use this chart below to write about your family. If additional space is needed you may write on the back or provide another attachment.

Family Member	Medical Diagnoses

International Patients Only:

1. Are you a US citizen living abroad: Yes No
2. Do you hold a valid passport currently: Yes No
3. Do you have a travel visa to visit the US currently: Yes No N/A
4. Have you ever been denied access to a passport: Yes No
5. Have you ever been denied access to a visa: Yes No

Please be advised though our transplant team may assist in obtaining Medical Visas it is not a guarantee and all costs of transport and lodging are the donor/recipients responsibility.

ALL international patients must provide the following test results BEFORE coming to the United States to be evaluated. We require official documentation of all results directly from the laboratory or hospital:

1. ABO (blood type)
2. Comprehensive Metabolic Panel (specifically creatinine)
3. Comprehensive Blood Count (white blood cells, red blood cells, hemoglobin, hematocrit)
4. Urinalysis (specifically urine protein and blood)
5. Renal ultrasound

Name: _____

INCREASED RISK DONORS

We are required to screen all potential organ donors for behavior that increase the risk of transmitting infectious diseases through transplantation using criteria established by the Public Health Service. Any donors who meet one or more of the criteria listed below are considered to be at an increased risk of spreading HIV, Hepatitis B or Hepatitis C. Signing below verifies you have read the list and will discuss whether you meet the criteria with different members of our donor team. If for any reason you meet criteria, by law the recipient must be informed you meet “increased donor risk” criteria. The specific reason you meet criteria will not be shared with the recipient. This will only be done after you have spoken with our team and have decided to continue as a donor.

We understand that these questions are very personal in nature and want you to be aware, prior to your interviews, that this information will be addressed by the physician and social worker that you see during your evaluation. Please be advised that “sex” refers to vaginal, anal and oral intercourse.

2013 PHS Guidelines for Increased Risk:

- People who have had sex with a person known or suspected to have HIV, HBV, or HCV infection in the preceding 12 months
- Men who have had sex with men (MSM) in the preceding 12 months
- Women who have had sex with a man with a history of MSM behavior in the preceding 12 months
- People who have had sex in exchange for money or drugs in the preceding 12 months
- People who have had sex with a person who had sex in exchange for money or drugs in the preceding 12 months
- People who have injected drugs by intravenous, intramuscular, or subcutaneous route for nonmedical reasons in the preceding 12 months
- People who have had sex with a person who injected drugs by intravenous, intramuscular, or subcutaneous route for nonmedical reasons in the preceding 12 months
- People who have been in lockup, jail, prison, or a juvenile correctional facility for more than 72 consecutive hours in the preceding 12 months
- People who have been newly diagnosed with, or have been treated for, syphilis, gonorrhea, *Chlamydia*, or genital ulcers in the preceding 12 months
- People who have been on hemodialysis in the past 12 months (Increased risk for recent HCV infection)

1. Patient Certification:

- The above US PHS Increased Risk Donor Criteria have been reviewed with me.
- I understand that if I meet any of the criteria above, my recipient must be informed that I am a high risk organ donor.
- I understand that my recipient cannot be informed of this information without my permission.

SIGNATURE OF PATIENT	DATE
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Name: _____

Living Donor Evaluation Consent

- I understand that I have chosen to be evaluated as a living kidney donor. Kidney donation is a choice and requires careful screening to make sure it is the right choice both medically and psychologically.
- I understand that in order to determine if donation is the right choice for me, multiple tests will be obtained including blood and urine tests, xrays and other tests. I may be asked to sign other consent forms for some of these tests.
- I understand that I will have to meet with members of the transplant team and other doctors.
- Even though I may go through the testing and see the specialists, if something is discovered during the testing/screening process, I may not be able to become a kidney donor.
- I understand that I will not be responsible for any medical bills related to my evaluation, testing or surgery for donation. However, if a previously unknown medical problem is found during my evaluation, I understand that I will be financially and personally responsible for further medical testing and follow up with my Primary Care Physician.
- I understand I will receive information from my transplant team about donation while I am being evaluated. This information will help me to make an informed decision about whether I will agree to be a donor. I know that if I have questions about any of the tests or the information, I can ask my doctor, transplant coordinator, independent donor advocate or other transplant team member.
- I agree to be evaluated for kidney donation. I understand that I may change my decision, discontinue my consent or may choose to stop the evaluation process any time during this evaluation. I understand that if I may decline, at any time, to donate my organ and this information will remain protected and confidential. (i.e., not communicated to recipient)
- I am willing to donate my kidney and I am free from inducement or coercion.
- I understand that an Independent Donor Advocate will be available to me during all phases of the donation process

Patient Signature

Date signed