INOVA®

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 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: 703-776-4735
Email: Kirsten.Curtis@inova.org
Mail: Attn: Kirsten Curtis
INOVA Kidney Transplant Center
3300 Gallows Rd
Falls Church, VA 22042

****If you do not hear from us within three business days of submitting your form, please call the office to confirm receipt****

Please feel free to contact the Living Donor Coordinator with any questions or concerns at 703-776-8053 or Kirsten.Curtis@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?_____
If yes, primary care physician's name and phone number? _____

Blood type_____

Name:_____

**The following tests need to be completed for the listed age groups prior to donating; you may submit this form before the tests have been completed. If these are not up to date, please work on updating with your primary care provider.**

**PLEASE FOLLOW CURRENT AMERICAN CANCER SOCIETY GUIDELINES:**
**ALL OF THESE TESTS ARE THE FINANCIAL RESPONSIBILITY OF THE DONOR**

Date of last Pap Smear:_____ Comment:_____

*-Women <21 should not be tested for cervical cancer*

*-Women age 21-29 should have a pap smear every 3 years*

*-Women age 30-65 should have a pap smear plus HPV test every 5 years, if pap smear alone, every 3 years*

Date of last Mammogram:_____ Comment:_____

*-Women age 45-54 should have a mammogram every year*

*-Women age 55 and older can switch to mammograms every 2 years*

Date of last Colonoscopy (or stool based test):_____ Comment:_____

*-Regular screening is now recommended to start at age **45.** This includes stool-based tests or structural exams (colonoscopy). Please discuss options with your PCP.*

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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 **currently** use drugs? Yes No
Have you previously 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 | | |
| Bipolar Disorder | | | Hormone Supplements | | |
| Bladder Infection or other 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 | | | Miscarriage (please list number) | | |
| Convulsions | | | Night Time Urination | | |
| Depression/Worry | | | Nose Bleeds | | |
| Diabetes | | | Numbness | | |
| Diabetes While Pregnant | | | Pacemaker | | |
| Diarrhea | | | Pregnancy (please list number of pregnancies) | | |
| Difficult Urination | | | Prostate Difficulties | | |
| Dizziness/Vertigo | | | Prostate Enlargement | | |
| Drug Addiction | | | Rectal Bleeding | | |
| Ear Drainage | | | Rheumatic Fever | | |
| Ear Ringing | | | Sickle Cell Anemia | | |
| Eating Disorders | | | Stroke | | |
| Fainting Spells | | | Swelling | | |
| Frequent Urination | | | Thyroid Imbalance | | |
| Glaucoma | | | Tuberculosis (TB) | | |
| Gout | | | Ulcers/Heartburn | | |
| Headaches | | | Urinary Tract Infection | | |
| Heart Attack | | | Vomited Blood | | |
| Heart Disease | | | Weight Change in the Last 6 Months | | |
| Heart Murmur | | | Jehovah's Witness | | |
| Hemorrhoids | | | LIST OTHER: | | |

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 |
|---|---|
| MOTHER: | |
| FATHER: | |
| Sibling 1: | |
| Sibling 2: | |
| Sibling 3: | |
| Child 1: | |
| Child 2: | |
| OTHER: | |

**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
6. Endemic disease testing as indicated on an individual basis

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 |
| --- | --- |
| | |

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 my transplant team will have access to any previous medical records in the EPIC electronic medical record.

- 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