The Transplant Institute
METHODIST DALLAS

Kidney Living Donor Intake Screening Form

Donor's Name: _____ DOB: _____ Age:_____ Male / Female

Phone Numbers: Cell:_____ Home : _____

Email:_____

Intended Recipient _____Relationship to Recipient:_____

When was the last time patient saw their PCP? _____ PCP: _____

Height: _____ Weight: _____ lbs/kg BMI_____

Does donor have health insurance? Yes ❒ No ❒ Years at current employer?_____

Diabetic :	Yes ❒	No ❒	Kidney Stones:	Yes ❒	No ❒	Smoker:	Yes ❒	No ❒
Gestational DM:	Yes ❒	No ❒	Recurrent UTIs:	Yes ❒	No ❒	Drug Use:	Yes ❒	No ❒:
HTN:	Yes ❒	No ❒	Cancers:	Yes ❒	No ❒			
Proteinuria:	Yes ❒	No ❒	Heart Disease:	Yes ❒	No ❒			
Hematuria:	Yes ❒	No ❒	Stroke:	Yes ❒	No ❒			

Current Medications:_____

Other Medical History:_____

_____

Does patient have a cardiologist? Yes ❒ No ❒ N/A ❒ Seen for/when?_____

Cardiologist:_____ Telephone # / Location:_____

Had a colonoscopy? Yes ❒ No ❒ N/A ❒ When? _____ Where?_____

Gastroenterologist: _____Telephone # / Location:_____

FEMALES: Date of last pap smear: _____ Hysterectomy? Yes ❒ No ❒

Date of last mammogram: _____ Telephone # / Location:_____

Gynecologist: _____ Telephone # / Location:_____

SURGICAL HISTORY:_____

_____

Additional Notes:_____

_____

_____ _____

Transplant Clinical Coordinator Signature **Date**