

Kidney Living Donor Intake Screening Form

Donor's Name: _____ DOB: _____ Age: _____ Male / Female
Phone Numbers: Cell: _____ Home : _____
Email: _____

Intended 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 <input type="checkbox"/> No <input type="checkbox"/>	Gestational DM:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Stones:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hematuria:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Proteinuria:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Recurrent UTIs:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Cancer:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Cancers:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke:	Yes <input type="checkbox"/> No <input type="checkbox"/>
HTN:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Smoker:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Illicit Drug Use:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other:	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Does patient have a cardiologist? Yes No N/A When were they last seen? _____

Heart Problems / Surgeries (dates): _____

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: _____

When/how did you learn about the recipient's need for a transplant? _____
Tell me about how you became the identified potential donor? _____
How long have you been considering donation? _____
Do you feel pressured to do something you don't want to do? _____

Transplant Clinical Coordinator Signature _____ **Date** _____