

The Comprehensive Transplant Center
 720 Rutland Avenue / Turner 34-36
 Baltimore, Maryland 21205
 (410) 614-9345 / Fax: (410) 614-6906
 Toll Free: 1(888) 304-5069, Option # 4, 2



Kidney Donor Questionnaire

Last Name: _____	First Name: _____	Blood Type: _____
Home Phone: () _____	Alternate Ph: () _____	
MR#: _____	Relationship to Recipient: _____	
Address: _____		
Email Address: _____		Date: _____

DOB: ____ / ____ / ____	SS#: _____	Marital Status: _____	Gender: <u>M</u> / <u>F</u>
# of Children: _____	HT: _____	Weight: _____	BMI: _____
		Race: _____	Religion: _____
Counseled on wt. loss/BMI goals? _____			

Mother's Name (First & Maiden) _____	Father's name: _____
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<u>Medical History:</u>	<u>Personal History</u>	<u>Family History</u>
Kidney Problems of any kind? Yes/No _____	Yes/No _____	Comments: _____
History of Kidney Stones? Yes/No _____	Yes/No _____	Comments: _____
History of Blood in Urine or UTI? Yes/No _____		
High Blood Pressure? Yes/No _____	Yes/No _____	Comments: _____
Diabetes: Yes/No _____	Yes/No _____	Comments: _____
Heart Disease: Yes/No _____	Yes/No _____	Comments: _____
Cancer? Yes/No _____	Yes/No _____	Comments: _____
Other Medical History: _____	Other Family History: _____	
Do you drink alcohol? Yes/No _____	If yes, frequency: _____	
Do you Smoke? Yes/No _____	If yes, frequency: _____	
History of drug abuse? Yes/No _____	Comments: _____	
Allergies: Yes/No _____	Comments: _____	
If not a match for your selected recipient, would you like to participate in the Non-Directed Donor Program? <u>Yes</u> / <u>No</u>		
Surgical History (list procedure and approximate dates) _____ _____		
Other Medical Issues: _____		
Medications: _____		
Highest Level of Education _____		Occupation: _____ FT / PT

Recipient's Info: (Who do you wish to donate to?)		
Last Name: _____	First Name: _____	DOB: _____
Diagnosis: _____	Blood Group: _____	Status: <u>Listed</u> / <u>Work-up</u> / <u>Inactive</u>
MR#: _____	Recipient's RN: _____	

(office use only)
 Donor RN Coord: _____ Draw date: _____ Brochure mailed _____ Scanned in TR _____

I.

- 1. Country of Birth _____ Are you a U.S. Citizen? _____
- 2. What is your primary language? _____
- 3. Do You require a translator? _____
- 4. Do you have any restrictions on receiving a blood transfusion if necessary, during the surgical procedure? _____

II.

- 1. Have you been tested as a kidney donor at any other transplant centers? _____
- 2. If yes, when? (date or *approximate date range*) _____
- 3. Please provide the name and telephone number of that Transplant Center below:

III.

- 1. Have you discussed kidney donation with your family? _____
- 2. If yes, are they supportive of your decision to donate? _____
- 3. Are you under any pressure to donate? _____

Why do you wish to donate a kidney?

Notes:

IV.

Employer: _____ Phone: _____

Address: _____

Health Insurance Company: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____

Alternative Contact Person: _____ Relationship: _____

Telephone: _____ Address: _____