



# KIDNEY TRANSPLANT PROGRAM

## Kidney Living Donor Referral Form

Thank you for your interest in living kidney donation! The Penn kidney transplant team is committed to helping you help others. To begin the referral process, please complete this survey and return to the Living Donor Team via fax at 215.615.3814, or send back to Penn Transplant Program, Living Kidney Donor Program, PCAM- 2 West, 3400 Civic Center Blvd., Philadelphia, PA 19104.

Once your referral form is received, a member of the kidney living donor team will contact you within two business days.

### Demographic Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Which is the best phone number to use to reach you during business hours?  home  work  cell

What is your current employment status?  full-time  part-time  self-employed  unemployed

Email Address: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status:  single  married  divorced  separated  cohabitating

Are you a U.S. Citizen?  Yes  No

If not a US citizen:  alien  non-resident alien

Nationality: \_\_\_\_\_ Date of entry into USA: \_\_\_\_\_ Visa status: \_\_\_\_\_

Return date to country of origin: \_\_\_\_\_

(Note: you will be required to show your passport or residency card at the time of initial appointment.)

Education Level:  grade school  high school  college/tech school  post graduate

Do you currently have health insurance?  Yes  No

Primary Care Physician (PCP) Name: \_\_\_\_\_  I do not have a PCP

PCP Address: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Additional physician name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Additional physician address: \_\_\_\_\_ Phone: \_\_\_\_\_

Additional physician name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Additional physician address: \_\_\_\_\_ Phone: \_\_\_\_\_

Kidney Transplant Recipient's Name: \_\_\_\_\_ Recipient's DOB: \_\_\_\_\_

Does your recipient know that you are considering donating?  Yes  No

What is your relationship to the patient:  Family (please specify) \_\_\_\_\_

Friend  Co-worker  None  I do not have a specific patient in mind

How were you referred to consider donation?  By a patient  friend/family  media source  other \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**General Health Screening**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

If you know your blood type, please indicate it and how you know \_\_\_\_\_

1. When were you last seen by a primary care physician or doctor? \_\_\_\_\_
2. Has a physician ever told you that you have high blood pressure?  Yes  No  Unknown
3. Does anyone in your family have high blood pressure?  Yes  No  Unknown
4. Has a doctor ever told you there are problems with your blood sugar?  Yes  No  Unknown
5. Does anyone in your family have diabetes or pre-diabetes?  Yes  No  Unknown
6. Has a doctor ever told you there is a problem with your heart such as a heart murmur or irregular heart beat?  Yes  No  Unknown  
If yes, what type of problem? \_\_\_\_\_
7. Have you ever had heart surgery?  Yes  No  Unknown  
If yes, what type? \_\_\_\_\_
8. Does anyone in your family have heart problems  Yes  No  Unknown
9. Do you have a history of cancer?  Yes  No  Unknown  
If yes, please specify the type of cancer and any treatment received. \_\_\_\_\_
10. Is there a history of cancer in your family?  Yes  No  Unknown  
If yes, please specify the family member and type of cancer. \_\_\_\_\_
11. Has a doctor told you that you have kidney problems?  Yes  No  Unknown  
If yes, what type of problem? \_\_\_\_\_
12. Does anyone in your family have kidney problems?  Yes  No  Unknown  
If yes, please specify the family member and type of problem. \_\_\_\_\_
13. Have you ever had a kidney stone or blood in your urine?  Yes  No  Unknown  
If yes, what type of treatment did you receive? \_\_\_\_\_
14. Have you ever been diagnosed with hepatitis B or C?  Yes  No  Unknown
15. Have you ever had surgery?  Yes  No  Unknown  
If yes, please specify the reason and type of surgery. \_\_\_\_\_
16. Has a doctor ever told you that you have bleeding problems?  Yes  No  Unknown  
If yes, please specify the type of bleeding problem. \_\_\_\_\_
17. Please list all medications you are currently taking:

Medication	Reason for taking	Dose	Frequency

18. Have you ever had any back or neck problems?  Yes  No  Unknown  
If yes, please describe the problem and any treatment received. \_\_\_\_\_
19. Have you ever been unable to work?  Yes  No  Unknown  
If yes, what was the cause? \_\_\_\_\_
20. Do you drink alcohol?  Yes  No  Unknown  
If yes, how often and how much? \_\_\_\_\_
21. Do you now or have you ever smoked tobacco?  Yes  No  Unknown  
If yes, how many packs a day and for how many years? \_\_\_\_\_
22. Do you use recreational drugs?  Yes  No  Unknown

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Completion of this routine health survey is required in order to be considered as a potential living donor.**

I, \_\_\_\_\_, give my permission to be contacted by  
the Penn Transplant Institute to receive more information about living donation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**How did you receive these screening forms?**

- Attended donor education session?
- Given to you by the recipient?
- Received by mail from the transplant program?

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**Penn Transplant Institute Use Only**

Referral initiation form received by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

MD reviewed by: \_\_\_\_\_

Discussed with potential donor: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Initials: \_\_\_\_\_

Education session scheduled: Date: \_\_\_\_\_

Medical records requested from:  potential donor  other: \_\_\_\_\_ Date: \_\_\_\_\_



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