Penn Medicine

Penn Transplant Institute

Hospital *of the* University *of* Pennsylvania

Kidney Transplant Program

Kidney Living Donor Questionnaire

Thank you for your interest in living kidney donation! The Penn kidney transplant team is committed to helping you help others. To begin the evaluation process, please complete this survey and return it to the Living Donor Team via **email:** kidneylivingdonorteam@uphs.upenn.edu **Fax at 215-243-2354**, or mail to: **Penn Transplant Institute, Living Kidney Donor Program, PCAM 2 West, 3400 Civic Center Blvd., Philadelphia, PA 19104**.

Once your referral form is received, a member of the living donor kidney team will contact you within one week. To facilitate the review process, please make every effort to answer all questions as thoroughly as possible.

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 ☐Homemaker

☐Not working due to disability ☐ Not working due by choice ☐ Retired

Email Address: _____

Race: _____ Marital Status: ☐single ☐married ☐divorced ☐widow ☐separated

☐Life partner ☐cohabitating

Are you a U.S. Citizen? ☐Yes ☐No

If not a US citizen, are you? ☐US resident ☐Non-resident traveled to US for reason other than transplant
☐Non-resident traveled to US for transplant Nationality: _____
Date of entry into USA: _____ Visa status: _____
Return date to country of origin: _____
(Note: you will be required to show your passport, residency card at the time of initial appointment.)

Education Level: ☐Grade school (0-8) ☐High school (9-12) or GED ☐Attended college/technical school

☐Associates/bachelors ☐Post graduate

Do you currently have health insurance? ☐Yes ☐No

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

What is your relationship to the patient (**please specify the relationship**) ☐brother ☐sister ☐in-law ☐ child

☐parent ☐niece/nephew ☐aunt/uncle ☐friend ☐co-worker ☐ Other _____

☐none ☐I do not have a specific patient in mind

How were you referred to consider donation? ☐By a patient ☐Friend/family ☐ Billboard ☐ Face book

☐ Craigslist ☐ Matchingdonors.com ☐ Bulletin from religious organization ☐Television or radio program

☐other, please specify _____

Have you met the intended recipient? ☐ Yes☐ No. If yes, how long have you known the intended recipient? _____

What is the intended recipients ***Name:*** _____ ***Date of Birth:*** _____

General Health Screening

Height: _____ Weight: _____ Blood type if known _____

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 If yes for how many years_____
3. Does anyone in your family have high blood pressure? ☐Yes ☐No ☐ Unknown If yes who _____
4. Has a doctor ever told you there are problems with your blood sugar? ☐ Yes ☐ No
5. Does anyone in your family have diabetes or pre-diabetes? ☐ Yes ☐ No ☐ Unknown If yes who_____
6. If you are a woman who has had children, have you ever been told you had gestational diabetes? ☐Yes ☐No ☐ NA
7. Do you have a problem with your heart such as a heart murmur or irregular heart beat? ☐Yes ☐ No
   If yes, what type of heart problem_____
8. Have you ever had heart surgery? ☐Yes ☐No If yes, what type?_____
9. Does anyone in your family have heart problems? ☐ Yes ☐ No ☐ Unknown
10. Do you have a history of cancer? ☐ Yes ☐ No
    If yes, please specify the type of cancer and any treatment received._____
11. Is there a history of cancer in your family? ☐ Yes ☐ No ☐ Unknown
    If yes, please specify the family member and type of cancer._____
12. Has a doctor told you that you have kidney problems? ☐Yes ☐No
    If yes, what type of problem?_____
13. Does anyone in your family (other than the recipient if they are a family member) have kidney problems?
    ☐Yes ☐ No ☐ Unknown
    If yes, please specify the family member and type of problem._____
14. Have you ever had a kidney stone or blood in your urine? ☐Yes ☐No
    If yes, what type of treatment did you receive?_____
15. Have you ever been diagnosed with hepatitis B or C? ☐ Yes ☐ No
16. Have you ever had surgery? ☐Yes ☐No If yes, please list the type of surgery.
    _____
17. Has a doctor ever told you that you have bleeding problems? ☐Yes ☐No
    If yes, please specify the type of bleeding problem._____
18. Have you ever suffered from depression or anxiety? ☐Yes ☐No
    If yes, are you currently under treatment? _____
19. Do you have any physical limitations? ☐Yes ☐No
    If yes, what are you limitations_____
20. Have you ever had any back or neck problems? ☐Yes ☐No
    If yes, please describe the problem and any treatment received._____
21. Have you ever been unable to work? ☐Yes ☐No
    If yes, what was the cause?_____
22. Do you drink alcohol? ☐Yes ☐No If yes, how often and how much?_____
23. Do you now or have you ever smoked tobacco? ☐Yes ☐No
    If yes, how many packs a day and for how many years?_____
24. Do you use recreational drugs? ☐Yes ☐No

25. If you are a woman, what is the date of your last pap smear? _____

26. If you are a woman over 40, what is the last date of your mammogram?_____

27. If you are over 50 years old, when are you do for your next colonoscopy?_____

28. Please list all medications you are currently taking including over the counter medications:

Medication	Reason for taking	Dose	Frequency

Primary Care Physician (PCP) Name: _____ ☐ I do not have a PCP

PCP Address:_____PCP Phone:_____

Additional physician name: _____ Specialty: _____

Additional physician address: _____ Phone: _____

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 intended recipient**
☐ **Received by mail or email from the transplant program after contacting Penn**
☐ **Downloaded from Penn Transplant website**

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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: _____

REV 9/3/15