Penn Transplant Institute

Penn Medicine

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**

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?

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: ____________