
Demographic Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Best Time to Contact: Morning (8 a.m. to noon) Afternoon (noon to 4 p.m.) (circle one)

Email Address: _____

Occupation: _____ Work Phone: _____

May we contact you at work: Yes No

US Citizen: Yes No

Social Security Number: _____ (for registration purposes only)

Marital Status: _____

Height: _____ Weight: _____ Race: _____ Sex: _____

Do you have children: Yes No If so, how many and ages: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Recipient Information

Recipient Name: _____ Recipient Date of Birth: _____

Relationship to Recipient: Family Friend Neighbor Coworker Other/None _____

Medical History

Primary Care Provider Name and Address: _____

Primary Care Provider Phone Number: _____

Do you currently have health insurance? Yes No

Allergies (medication/food): _____

Are you allergic to Latex? Yes No

Are you allergic to IV contrast or Shellfish? Yes No

MEDICAL HISTORY

Medical (SELF)	Yes	No	Medical (FAMILY)	Yes	No	Relationship
High Blood Pressure			High Blood Pressure			
Diabetes			Diabetes			
Heart Disease			Heart Disease			
Cancer: _____type			Cancer: _____type			
When: _____						
Melanoma: _____						
Lung Issues			Lung Issues			
Tuberculosis/Positive TB Skin			Tuberculosis/Positive TB Skin			
Anemia			Anemia			
Kidney Stone: year _____			Kidney Stone: year _____			
Migraines/Chronic Headaches			Migraines/Chronic Headaches			
Seizures			Seizures			
Bladder Infection			Bladder Infection			
Gynecological Issues			Gynecological Issues			
Lupus			Lupus			
Dizziness/Memory Loss			Dizziness/Memory Loss			
Stomach/Intestine Issues			Stomach/Intestine Issues			
Herpes			Herpes			
Prostate Issues			Prostate Issues			

Psychosocial	Yes	No	Office Notes:
Body Piercings/Tattoos			
Do you smoke? If so,			
how many packs per day. ____			
Alcohol Use:			
_____ amount per day			
_____ amount per week			
_____ amount per month			
History of Drug Use			
History of Depression			
History of Bulimia/Anorexia			

Please list your medications and their dosages: (Use additional paper, if necessary)

Medication	Dosage	How often?

Please list all your surgeries and dates they occurred: (Use additional paper, if necessary)

Surgery	Date	Location

Have you traveled outside of the country in the past 6 months? If yes, where? _____

Please have blood pressure check and record here _____/_____

Date: _____ Taken where: _____

If your reading is greater than 140/80, please provide an additional reading _____/_____

What is your desired timeframe for donation? 3-6 months 6 months - 1 year greater than 1 year

How did you hear about being a living donor? Family Friends Community

___ Social media, please specify _____ Other, please specify _____

Current National and Program specific transplant recipient outcomes are updated every six months and the data can be found on the Scientific Registry of Transplant Recipient at srtr.org. There currently are no national or center specific outcomes for living donors calculated by the Scientific Registry of Transplant Recipient. If you have questions about this data or how to use the website, you can discuss this with your living donor team member.

I have read and understand the patient educational material presented to me for potential living donors. I have answered these questions to the best of my ability and without coercion. I understand that I can change my mind at any time about being a living donor. I would like to proceed with my evaluation if I am an appropriate candidate.

At this time, my willingness to donate on a scale from 1-10 is _____.

Signature: _____ Date: _____

For Office Use Only

Date Received: _____

Assigned to: _____

Reviewed by: _____

BMI _____ / MRN _____

ILDA Team Member Signature: _____

DATE: _____