Atrium Health

# Potential Living Donor Referral Form

**Demographic Information (Please print)** **(Use blue or black ink)**

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 (circle one)

US Citizen: Yes/No (circle one)

Social Security Number: _____ (for registration purposes only)

Marital Status: _____

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

Do you have children: Yes/No (circle one) If so, how many and ages: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

## Recipient Information

Recipient Name: _____ Recipient Date of Birth: _____

Relationship to Recipient: Family (please specify) _____ 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 (circle one)

Allergies (medication/food): _____

Are you allergic to Latex? Yes/No (circle one)

Are you allergic to IV contrast or Shellfish? Yes/No (circle one)

# 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? (Circle one) 3-6 months 6 months - 1 year greater than 1 year

How did you hear about being a living donor? (Circle one)

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: _____

_____

Transplant Center
PO Box 32861 | Charlotte, NC 28232
Phone: 704-355-3602 | Fax: 704-355-4910
**AtriumHealth.org**