LIVING DONOR ASSESSMENT

Date: _____

Person You Wish To Donate To: _____ MRN: _____

Relationship: _____ Recipient's Blood Type: _____ Transplant No: _____

Disease: _____ Transfusion History: _____

DONOR'S PERSONAL HISTORY

Name: _____ Maiden Name: _____

Address: _____ City / State: _____

Zip Code: _____ County: _____

Home Number: _____ Work Number: _____

Cell Number: _____ Which Number Is Primary? _____

Age: _____ Date of Birth: _____ SEX: ☐ Male ☐ Female

What Type Of Work Do You Do? _____

Race: _____ Social Security # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Height: _____ Weight: _____ Do You Have Health Insurance? ☐ Yes ☐ No

Family Physician Name & Phone Number: _____

Emergency Contact Name & Phone Number: _____

With Whom May We Share Your Appointments / Health Information? _____

Recreation / Exercise: _____

Drug Allergies: _____ Latex Allergy: ☐ Yes ☐ No

Food Allergy: ☐ Yes ☐ No Type: _____ Iodine Allergy: ☐ Yes ☐ No

Do You Know Your Blood Type? ☐ Yes ☐ No If Yes, Please Specify: _____

Alcohol: *(Average Per Day)*	Type:	Amount:	
Tobacco: *(Average Per Day)*	Type:	Amount:	
Illicit Drugs: *(Average Per Day)*	Type:	Amount:	
Protein Supplements: *(Average Per Day)*	Type:	Amount:	

LIVING DONOR ASSESSMENT

DO YOU HAVE / OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Please Check YES, NO or FAMILY member:

	Yes	No	Family		Yes	No	Family
Anemia	☐	☐	☐	HIV/AIDS	☐	☐	☐
Arthritis	☐	☐	☐	Kidney Disease	☐	☐	☐
Back Problems	☐	☐	☐	Bladder/Kidney Infections	☐	☐	☐
Blood Disease	☐	☐	☐	Kidney Stones	☐	☐	☐
Cancer	☐	☐	☐	Blood In Urine	☐	☐	☐
Chemical Dependency	☐	☐	☐	Painful Urination	☐	☐	☐
Circulatory Problems	☐	☐	☐	Tuberculosis	☐	☐	☐
Congenital Heart Disease	☐	☐	☐	Liver Disease	☐	☐	☐
Diabetes	☐	☐	☐	Stroke	☐	☐	☐
Depression	☐	☐	☐	Mitral Valve Prolapse	☐	☐	☐
Emphysema	☐	☐	☐	MRSA Infections	☐	☐	☐
Epilepsy	☐	☐	☐	Pacemaker	☐	☐	☐
Heart Murmur	☐	☐	☐	Pneumonia	☐	☐	☐
Heart Disease	☐	☐	☐	Prostate Problems	☐	☐	☐
Hepatitis (type ____)	☐	☐	☐	Respiratory Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐	Sleep Apnea	☐	☐	☐
Shortness of Breath	☐	☐	☐	Ulcerations	☐	☐	☐
Thyroid Problems	☐	☐	☐	Toxemia	☐	☐	☐
Blood Clot	☐	☐	☐	Gestational Diabetes	☐	☐	☐
Valley Fever? (when _____)	☐	☐	☐	Lived in Southwest U.S. or Northern Mexico?	☐	☐	☐

If yes to any of the above questions, please explain. Please list relationship to any questions marked "family".

MEDICINES:

Medicines Taken Regularly (Prescription & Over The Counter):

TYPE	REASON	LAST DOSE

Medicines Taken In Past:

TYPE	REASON	LAST DOSE

LIVING DONOR ASSESSMENT

FEMALES:

Date of Last PAP Test: _____ Date of Last Mammogram: _____

Number of Children & Ages: _____

SURGICAL HISTORY:

List Any Operations You Have Had (Including Childhood):

	SURGERIES / PROCEDURE	LOCATION	DATE
1:			
2:			
3:			
4:			
5:			
6:			
7:			
8:			
9:			
10:			
11:			
12:			
13:			
14:			

HOSPITALIZATIONS / DRUG OR ALCOHOL TREATMENT / PSYCHIATRIC TREATMENTS:

	REASON / DIAGNOSIS	HOSPITAL	DATES
1:			
2:			
3:			
4:			
5:			
6:			
7:			
8:			

LIVING DONOR ASSESSMENT

FAMILY HISTORY:

	NAME	PRESENT AGE (OR AGE OF DEATH)	IF LIVING, HEALTH STATUS – *(GOOD, FAIR POOR)* IF DECEASED, CAUSE OF DEATH
Father:			
Mother:			
Sibling 1:			
Sibling 2:			
Sibling 3:			
Sibling 4:			
Sibling 5:			
Sibling 6:			
Sibling 7:			
Sibling 8:			

Is your spouse / significant other supportive of you donating? _____

Will donation create a financial burden? _____

Does your employer know? _____

Are they supportive? _____

Do you have any reason why you would not accept blood products? ☐ Yes ☐ No

Explanation: _____

If you know your blood type, please include a **COPY OF YOUR BLOOD TYPE** with this form and return them to:

The Ohio State University Wexner Medical Center
Comprehensive Transplant Center
Pre Transplant Office
770 Kinnear Road, Suite 100
Columbus, OH 43212

Phone: 614-293-6724
Toll Free: 800-293-8965
Fax: 614-293-6710