The Christ Hospital Health Network

DONOR REGISTRATION INFORMATION

Phone: 513-585-2493 Fax: 513-585-0433

(Please be advised donor information is needed ONLY to register donor in the Christ Hospital system. The recipient will be the guarantor and the recipient's insurance will be billed for all donor services. Without this information we cannot order any donor tests.)

Date: _____ Name:_____ Preferred name _____

(Full legal name with middle initial)

DOB:_____ SS#:_____ Marital status:_____

Race_____ Hispanic? Yes / No Preferred language:_____

Religious Preference:_____ Height _____Weight _____ Blood Pressure _____

Primary Care Physician Name/ Phone #: _____

Donor Address: _____City/ST: _____Zip:_____

County:_____ Email:_____

Home Ph#:_____ Cell Ph#:_____ Work Ph#_____

Best way to contact you during the day? (circle one) Home Ph # / Cell Ph # / E-Mail

Emergency Contact: _____ Relationship:_____

Home Ph #:_____ Cell Ph #:_____

Emergency Contact Address:_____

Donor Place of Employment: _____Job Title:_____

Employer Address:_____ Work #:_____

Donor Insurance Name:_____ Subscriber Name:_____

Insurance Address & Ph #:_____

ID#: _____ Group Name & #:_____

Name of Recipient: _____ Recipient's DOB (if known)_____

Relationship to Recipient: _____

(Example: mother, father, sister, brother, friend, etc)

For Internal Use Only

Recipient _____ Ordering Nephrologist_____

Recipient MR# _____ SW_____ Recipient ESRD_____

Recipient DOB_____

Donor Medical Record #_____

INFORMATION GIVEN IN THIS QUESTIONNAIRE WILL REMAIN CONFIDENTIAL AND AVAILABLE TO THE CHRIST HOSPITAL TRANSPLANT TEAM ONLY

The United Network for Organ Sharing (UNOS) instituted policy changes for all living organ donation. The Organ Procurement and Transplantation Network (OPTN) Policy 14.0 requires that transplant centers assess all potential living donors for increased risk for disease transmission, particularly HIV, Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV). Questions to identify individuals at increased risk were defined by the 2013 Public Health Services (PHS) Guideline. www.publichealthreports.org The purpose of this policy is to reduce the risk of transmissible disease in living donation and transplant. We understand that these questions are very personal in nature and therefore wanted you to be aware, prior to your interviews, that this information will be addressed during your medical evaluation and your meeting with the social worker. Responses will be kept strictly confidential and only available to our Transplant Team.

Please note: the definition of "had sex" in the questions below refers to any method of sexual contact, including vaginal, anal, and oral contact.

	Not Applicable	YES	NO
Have you had sex with a person known or suspected of having HIV, HBV, or HCV infection in the preceding 12 months?			
For Male Donors: Have you had sex with another man in the preceding 12 months?			
For Female Donors: Have you had sex with a man who has had sex with another man in the preceding 12 months?			
Have you engaged in sex in exchange for money or drugs in the preceding 12 months?			
Have you had sex with a person who had sex in exchange for money or drugs in the preceding 12 months?			
Have you had sex with a person who injected drugs by intravenous, intramuscular or subcutaneous route for nonmedical reasons in the preceding 12 months?			
A child who is < 18 months of age and born to a mother known to be infected, or at risk for HIV, HBV, or HCV infection	X		
A child who has been breastfed within the preceding 12 months and the mother is known to be infected with or at increased risk for, HIV infection.	X		
Have you injected drugs by intravenous, intramuscular, or subcutaneous route for nonmedical reasons in the preceding 12 months?			
Have you been in lockup, jail, prison, or a juvenile correction facility for more than 72 consecutive hours in the preceding 12 months?			
Have you been newly diagnosed with, or have been treated for, syphilis, gonorrhea, Chlamydia or genital ulcers in the preceding 12 months?			
Have you been on hemodialysis in the preceding 12 months?			

Signature: _____ **Date:** _____

Please Check **Yes** or **No** to the following questions:

Have you ever been treated for the following?	YES	NO	Have you ever been treated for the following?	YES	NO
Abdominal Pain			Hormone Supplements		
Alcohol abuse			Impaired Hearing		
Anemia			Impaired Vision		
Anxiety			Irregular Heartbeat		
Arthritis			Kidney Biopsy		
Backache			Kidney Infection		
Bladder Infection			Kidney Injury		
Bladder Problem			Kidney Stones		
Bleeding Problems			Leg Cramps		
Blood Disorders			Leg Pain		
Blood in Urine			Liver Disease		
Blood Transfusions			Long Term Skin Disease		
Blood Clot			Lung Disease		
Bruising			Lupus		
Cancer			Marijuana Use – Amt per day / Date last used		
Cataracts			Menstrual History		
Change in Bowel Habits			Miscarriage		
Chest Pain			Night Time Urination		
Chronic Pain			Nose Bleeds		
Concussion			Numbness		
Congestive Heart Failure			Pacemaker		
Constipation			Polycystic Kidney Disease		
Convulsions			Pregnancy		
Depression/Worry			Prostate Difficulties		
Diabetes			Prostate Enlargement		
Diabetes while Pregnant (Gestational)			Protein in urine		
Diarrhea			Rectal Bleeding		
Difficult Urination			Rheumatic Fever		
Dizziness/Vertigo			Sickle Cell Anemia		
Drug Addiction			Smoke Cigarettes – How Many per day?		
Ear Drainage			Street (Illicit) Drug Use – Name / Date last used		
Ear Ringing			Stroke		
Eating Disorders			Swelling		
Fainting Spells			Thyroid Imbalance		
Frequent Urination			Tuberculosis		
Glaucoma			Ulcers/Heartburn		
Gout			Urinary Tract Infection		
Headaches			Venereal Infection		
Heart Attack			Vomited Blood		
Heart Disease			Weight Change within last 6 months		
Heart Murmur					
Hemorrhoids					
Hepatitis					
Herpes					
Hiatal Hernia					
High Blood Pressure (Hypertension)					
Hormone Imbalance					

If you have answered "Yes" to any of the previous questions, please use this space to provide us with as much detail as possible, including dates and any other pertinent data.

1._____

2._____

3._____

4. _____

Please check Yes or No to the following Questions. Also, if you check Yes to any of the questions please give us as much detail as possible, including what family members and any pertinent information.

	Yes	No	Comments-Please use this field to provide any pertinent information
Do you have a family history of Heart Disease? If Yes please explain.			
Do you have a family history of Cancer? If so what type?			
Do you have a family history of Kidney Cancer? If yes, please explain.			
Do you have a family history of Kidney Disease? What Type if known.			
Do you have a family history of Diabetes? If yes, please indicate Type I or Type II if known.			
Do you have a family history of high blood pressure (hypertension)?			

Please list prior surgeries / hospitalizations:

Date Reason Hospital (City, State) Doctor

1._____

2._____

3._____

Any additional questions or comments?

1._____

2._____

3._____

List all medications you are currently taking including all over-the- counter medicines /Birth Control pills/Hormone Replacement Therapy /herbals/supplements:

1._____ 3. _____

2. _____ 4._____

Do you have prescription coverage? Yes No

Do you have any known allergies? Please list and what type of allergic reaction did you experience?

_____

_____

Will it be difficult for you to take time off of work to donate and recuperate? Yes_____ No_____

If yes, please explain_____

What is your blood type? (If known) _____

In the event that you are ABO incompatible (you don't share the same blood type or compatible blood type) **with the intended recipient; would you consider donating through our participating Kidney Exchange Program (KEP), the National Kidney Registry (NKR)?**

_____ Yes _____ No _____ Maybe

***** Please refer to the right side of your green folder for more information concerning the NKR.**

Why do you wish to donate?_____

_____

_____

Thank you for your interest in Kidney Donation! We appreciate you taking your time in completing this packet with such accuracy and so much detail. We use this information in determination of your eligibility for potential kidney donation. When I receive these forms, I will contact you regarding the next steps in the donation process.