



Dear Kidney Donor:

Welcome to The Christ Hospital Health Network Kidney Transplant department. There are two Kidney Transplant Donor Coordinators, Tricia Monson and Jessica Enzweiler. Both are registered nurses. As Kidney Transplant Donor Coordinators for The Christ Hospital Health Network, we are here to assist you in the donation process. We will schedule tests, provide education and answer questions that you may have to make the best decision regarding donation. We are your ADVOCATE.

Thank you for your interest in kidney donation. In this packet you will find the following: the registration form, donor questionnaire, release of protected health information form, social work questionnaire, TB Screening Questionnaire, donor informed consent, and information on living donation. We hope the donation information provided is helpful. Please share this information with your loved ones.

If you decide you want to move forward, please complete and return the registration forms. Once the forms have been reviewed, we will contact you. If you are a candidate, we will register you into our system and provide you with instructions for tissue typing. It is important that the tissue typing is coordinated with the timing of your recipient's tissue typing. Our staff in the transplant clinic will orchestrate the timing of the appointments. You must have tissue typing completed within a 24 to 48 hour period of the recipient. You will need to call Gail Krisko at 513-585-0803 to make your appointment. **Remember, you must be registered before you can make an appointment for tissue typing.**

Tissue typing or "matching" is determined by blood tests that look at protein markers and blood type. Your blood is matched against the recipient's blood for a reaction. This test takes three weeks to get the results. The results are then reviewed by the transplant team to determine the best match for the recipient. You will be contacted with the results.

If you are selected as the prospective donor, we will ask you to complete the transplant work-up (evaluation) at The Christ Hospital Health Network. A 'routine' work-up includes meetings with a donor coordinator, social worker & nurse practitioner. It also includes blood work, urine tests, EKG, & chest x-ray. Depending on age women will need a yearly mammogram, clinical breast exam, and Pap smear. Depending on age men will need prostate exams. Men and women over 50 need a colonoscopy. A CT-Angiogram of the abdomen is also ordered. We use this imaging specifically to examine the anatomy of the kidneys. A surgeon will determine which kidney is selected for donation based on the results of this imaging.

When your work-up (evaluation) is complete, The Christ Hospital Health Network Transplant Team will review your health record. You will be notified of your donation candidacy. The options include: approval, disqualification, or additional testing. When both the recipient and donor have received final approval, a transplant date can be scheduled.

It is important that you know that you can choose to discontinue the donation process at any time and your decision will remain confidential. Please do not hesitate to contact your coordinator with any questions.

We look forward to working with you and wish you the best.

Best regards,

Tricia Monson, RN

Jessica Enzweiler, RN

Tricia Monson, BSN, RN

Jessica Enzweiler, RN

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: _____ Age _____ Sex: Male _____ Female _____ 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#: _____

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 phone: _____

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 risk factors for acute transmission of HIV, Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) infection. Questions to identify individuals with risk factors were defined by the 2020 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, your meeting with the social worker, and pre admission testing if you proceed with donation. 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. Risk criteria is for the 30 days before organ procurement.

Donor Risk Factors	Not Applicable	YES	NO
Have you had sex with a person known or suspected of having HIV, HBV, or HCV infection in the preceding 30 days?			
For Male Donors: Have you had sex with another man in the preceding 30 days?			
Have you engaged in sex in exchange for money or drugs in the preceding 30 days?			
Have you had sex with a person who had sex in exchange for money or drugs in the preceding 30 days?			
Have you injected drugs by intravenous, intramuscular, or subcutaneous route for nonmedical reasons in the preceding 30 days?			
Have you had sex with a person who injected drugs by intravenous, intramuscular or subcutaneous route for nonmedical reasons in the preceding 30 days?			
Have you been incarcerated (confinement in jail, prison, or a juvenile correction facility) for equal to or greater than 72 consecutive hours in the preceding 30 days?			
A child who has been breastfed by a mother who is known to be infected with HIV infection.	X		
A child born to a mother with HIV, HBV, or HCV infection	X		
Unknown medical or social history			

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. Any family history of kidney stones or cysts?			
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.

**THE CHRIST HOSPITAL
TRANSPLANT SOCIAL WORK
Pre-Transplant Social History
Donor Assessment**

(Please answer all questions. Each question is important, but no single question will rule you out as a donor. It is best to answer all questions honestly and completely as possible.)

Name: _____
Address: _____
City: _____
Zip: _____
Your Relationship to Recipient _____

DOB: _____
Email: _____
Home phone: (____) _____ - _____
Cell phone: (____) _____ - _____
Your citizenship _____

FAMILY/SOCIAL INFORMATION (Use back of page as needed)

Immediate Family

Marital Status: ___ Single ___ Married (If married, for how long? _____) ___ Separated ___ Divorced

Home status: ___ Own ___ Rent ___ Household of another

Who lives in your home?

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Extended Family

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are the most common family conflicts within your immediate and/or extended family? _____

Early Life:

Where were you born and raised? _____

What was life like for you growing up? (Parents married? Divorced? Conflicts?) _____

How would you describe your "role" within your family growing-up? Circle one.

"The Responsible One", "The Black Sheep", "The Peacemaker", "The People-Pleaser", "The Invisible One", "The Joker", Other _____

Did you experience significant loss as a child? (Death of parent? Grandparent? Close friend? Loss of friends due to changing schools?) _____

Did you experience any traumatic incidents during childhood such verbal, physical or sexual abuse? _____
If yes, what happened? _____

What was school like for you most of time? _____

Were you in sports or other activities? _____

What was your favorite year of school? _____ Why? _____

Living Donation

Does the recipient know that you hope to donate? _____ If so, what was his/her response _____

How often do you have contact with the recipient? _____

What is the cause of the recipient's kidney failure? _____

Describe the changes in the recipient's life that you expect to see during the first year after transplant. _____

What other treatment options are available to the recipient? _____

Have you ever donated blood or done volunteer work? _____

What are your main reasons for wanting to donate?

1) _____

2) _____

What circumstances might cause you to change your mind about donating? _____

Potential donors are often disqualified in the early stages of their workup. Have you considered this possibility? How do you imagine you will feel? _____

If you are able to donate, how will your life change as the result the recipient receiving your kidney? _____

If you were to decide not to donate how do you imagine your relationship with the recipient might change? _____

Do you feel confident in your decision to be worked-up as a potential donor? _____

Most donors have some reservations about donating during the early stages of their workup. Do you have any? _____

If so what are they? _____

Do you have concerns about the medical and surgical risks involved in donating? _____

How does your spouse or significant other (or parent) feel about your wish to donate? _____

To what extent do they understand the potential risks to your health as a result of your donating? _____

Do you have a Living Will? _____

If you have religious beliefs, regardless of denomination or religion, how have these beliefs effected your decision to donate? Also, have your beliefs affected how you think the transplant and your recovery will go? _____

Please list your biggest worries about donating?

1. _____
2. _____
3. _____

Post-Surgical Recovery Plan

Where will you stay once discharged from the hospital? _____

Who will drive you there? _____

Who will be your primary caregiver once you are discharged from the hospital? _____

Who will be your secondary caregiver? _____

If you have young children, who will look after them, get them to school, etc.? _____

Donors are typically off from work for 4-6 weeks. Will being off from work for several weeks create financial hardship for you? _____ Do you have FMLA? _____ Short term Disability? _____ If so, at what % _____

Who could you turn to for a loan if you needed financial help while you were off from work? _____

You will not be able to lift anything weighing more than 10lbs for 6-8 weeks. Will this present a problem for you at work? _____ At home? _____ (Remember young children, pets, and household items can easily weigh more than 10lbs.)

Activities

Are you active in any clubs, religious or social organizations? _____ If yes, please list:

1. _____
2. _____
3. _____

What are your favorite things to do to relax and enjoy yourself?

1. _____
2. _____
3. _____
4. _____

Education/Employment

What was the last grade of school you completed? _____

Where did you go to school? High School _____ College/Grad School _____

Are you currently employed? _____ Yes _____ No

If yes, what is the name of your employer? _____

Please describe in detail what you do at work. _____

How long have you worked there? _____

Have you discussed donating with employer? _____ Yes _____ No

If yes, describe employer's response: _____

Do you have medical insurance? If so, what is it? _____

Are you eligible for short-term disability? _____ Yes _____ No FMLA _____ Yes _____ No

Is your Spouse/S.O. employed? _____ Yes _____ No

If yes, where? _____

Medical Information

Name of your Primary Care Physician/Phone: _____ (____) _____

Please list all past surgeries: 1. _____ 2. _____
3. _____ 4. _____

Do you exercise regularly? If so, describe what you do and how often.

How well would you say that you cope with stress? Pretty well _____ So So _____ Not good at all _____

Describe a time in your life that was very stressful. What was going on? _____

What did you do to help yourself cope with the stress? _____

Lifestyle

Do you think you live a healthy lifestyle _____? How much water do you usually drink a day? _____

What medication(s) do you usually take for minor aches and pain? _____

Do you smoke? Yes _____ No _____ If yes, how much? _____ How long have you smoked? _____ If you smoked previously, when did you quit? _____

Do you drink alcohol? Yes _____ No _____ If yes, what is your drink of choice? _____

How many drinks per week on average? _____ Have you ever been treated for alcohol abuse? _____ Yes _____ No

Do you smoke marijuana? _____ If yes, how many times a day/week? _____

If you smoke marijuana regularly, would you be able to stop prior to donation _____?

Have you ever taken prescription medicines? _____ Yes _____ No

On average, how many hours of sleep do you get per night? _____

Have you had any appetite changes within the past month? _____

Have you ever been diagnosed with an eating disorder? _____ Yes _____ No If yes, please describe; include when and for how long you were bulimic, anorexic and whether or not you purged. _____

Are you currently being treated with medication for depression or anxiety? _____ Yes _____ No If so, why are they being prescribed? _____ Do they help? _____

Have you been diagnosed with a psychiatric illness? _____ Yes _____ No If yes, what is your current treatment? _____ Have you seen a counselor, a psychiatrist, or a psychotherapist? _____ Yes _____ No If yes, when and for how long were you in treatment? _____

Please briefly describe the circumstances and whether you found it helpful. _____

Thank you for completing this form. Please sign and date.

Signature: _____ Date _____



The
Christ Hospital™
Health Network

**Kidney Transplant Center
TB Screening Questionnaire**

Donor Name (Print): _____ **DOB:** _____

1. Do you have a history of a positive TB Skin Test or history of having TB? **Yes** **No**

2. Do you now have any condition requiring prolonged steroid or immunosuppressive therapy? **Yes** **No**

3. Do you have an immunosuppressive illness at the present time? **Yes** **No**

4. Have you had any of the following in the past year (12 months)?
 - Recent close contact with a person having active Tuberculosis? **Yes** **No**
 - Unexplained productive cough? **Yes** **No**
 - Coughing up blood? **Yes** **No**
 - Unexplained weight loss or increased fatigue? **Yes** **No**
 - Unexplained fever or night sweats? **Yes** **No**

5. Have you had the BCG vaccine? **Yes** **No**

Signature: _____ **Date:** _____

TRANSPLANT NUTRITION ASSESSMENT FORM - Donor

Name: _____ Date of Birth: _____

(Each patient who is evaluated for an organ transplant is assessed by a Registered Dietitian.)

1. Height _____ Weight _____ Please circle if you are a Donor or Recipient

2. Three months ago, I weighed _____ pounds. Six months ago, I weighed _____ pounds.

3. A special diet/nutrition program that you may follow (check all that apply):

Low Fat Low Sodium Diabetic Renal High Protein
 Weight Loss No Gluten Vegetarian Vegan No Dairy

Other: _____

4. Food allergies/intolerances: _____

5. In the past three months, my appetite has: Increased Decreased Not Changed

6. Problems that affect your food intake (check all that apply):

Food doesn't taste good Loss of appetite I get full too fast
 Chewing problems Swallowing problems Nausea
 Heartburn/reflux Food smells bad Other _____

7. Which meals do you eat regularly (check all that apply):

Breakfast Lunch Dinner/Supper Snacks Skip meals often

8. Do you take any nutritional supplements such as Ensure, Boost, Nepro, Herbal Supplements, or others?

No Yes (please list) _____

9. Daily fluid intake:

Less than 3 cups 3-5 cups 6-8 cups More than 8 cups

Doctor orders: _____

10. I have skin wounds/sores that are healing slowly: No Yes

If yes, where? _____

11. Do you exercise? No Yes

If yes, how often _____ Type of exercise: _____

Physical limitations to exercise: _____

12. Do you have any nutritional concerns? Please describe. _____

Patient signature: _____ Date: _____

Renal Transplant Dietitian signature: _____ Date: _____