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 Gall 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 # __________________________
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.*

<table>
<thead>
<tr>
<th>Donor Risk Factors</th>
<th>Not Applicable</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Have you had sex with a person known or suspected of having HIV, HBV, or HCV infection in the preceding 30 days?</td>
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<tr>
<td>For Male Donors: Have you had sex with another man in the preceding 30 days?</td>
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<tr>
<td>Have you engaged in sex in exchange for money or drugs in the preceding 30 days?</td>
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<tr>
<td>Have you had sex with a person who had sex in exchange for money or drugs in the preceding 30 days?</td>
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<tr>
<td>Have you injected drugs by intravenous, intramuscular, or subcutaneous route for nonmedical reasons in the preceding 30 days?</td>
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<tr>
<td>Have you had sex with a person who injected drugs by intravenous, intramuscular or subcutaneous route for nonmedical reasons in the preceding 30 days?</td>
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<td>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?</td>
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<tr>
<td>A child who has been breastfed by a mother who is known to be infected with HIV infection.</td>
<td>X</td>
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<tr>
<td>A child born to a mother with HIV, HBV, or HCV infection</td>
<td>X</td>
<td></td>
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<tr>
<td>Unknown medical or social history</td>
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</tbody>
</table>

Signature: ___________________________  Date: ________________
Please Check **Yes** or **No** to the following questions:

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments-Please use this field to provide any pertinent information</th>
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</thead>
<tbody>
<tr>
<td>Do you have a family history of Heart Disease?</td>
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<td>If Yes please explain.</td>
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<td>Do you have a family history of Cancer?</td>
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<td>If so what type?</td>
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<td>Do you have a family history of Kidney Cancer?</td>
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<tr>
<td>If yes, please explain.</td>
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<tr>
<td>Do you have a family history of Kidney Disease?</td>
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<tr>
<td>What Type if known. Any family history of kidney stones or cysts?</td>
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<tr>
<td>Do you have a family history of Diabetes?</td>
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<tr>
<td>If yes, please indicate Type I or Type II if known.</td>
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<tr>
<td>Do you have a family history of high blood pressure (hypertension)?</td>
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</table>

Please list prior surgeries / hospitalizations:

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Hospital (City, State)</th>
<th>Doctor</th>
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<td>1.</td>
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<td>3.</td>
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</table>

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.
(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?

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Extended Family

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to you</th>
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</table>

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.
“\textbf{The Responsible One\textsuperscript{a}}”, “\textbf{The Black Sheep\textsuperscript{b}}”, “\textbf{The Peacemaker\textsuperscript{a}}”, “\textbf{The People-Pleaser\textsuperscript{b}}”, “\textbf{The Invisible One\textsuperscript{a}}”, “\textbf{The Joker\textsuperscript{a}}”, 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. __________________________________________

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? Yes ___ No ___ 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: ___________________________

Created: 06/19/17
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: ____________________________

Created: 1/4/17, 8/22/18, 1/14/20, 2/17/21