Please complete this form giving specific information whenever possible. Return the questionnaire in the enclosed self-addressed stamped envelope. Thank you.

Today's Date: _____

Recipient's Name: _____

Your relationship to recipient: _____

Are you blood related to recipient? YES NO

Social Security Number (Mandatory):_____

Your Name: _____Date of Birth_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Other Phone: _____

Are you working? _____ Full Time_____ Part Time_____ Retired_____

If yes, what type of work do you do? _____

Height _____ Weight _____ Race _____

Marital Status: Single Married Divorced Separated Widowed

Number of children and their ages: _____

Do you know your blood type? _____ If yes, circle: A B AB O

On a scale of 1-10 (with 10 being very willing to donate and 1 not willing to donate at all) how do you feel about being an organ donor?

1 2 3 4 5 6 7 8 9 10

Do you have allergies? YES NO

If yes, what are you allergic to? _____

Have you ever had a reaction to iodine (CT Dye) YES NO

If you have asthma, a special medication protocol will be required for CT studies.

Have you ever been treated for any of the following problems?

Kidney Infection YES NO

Bladder Infection YES NO

Heart Disease YES NO

High Blood Pressure (HBP) YES NO

Stroke YES NO

Heart Attack YES NO

Blood Clot YES NO

Lung Disease YES NO

Asthma YES NO

Diabetes YES NO

Gestational Diabetes YES NO

GERD YES NO

Liver Disease YES NO

Hepatitis YES NO

Pancreatitis YES NO

Arthritis YES NO

Lupus YES NO

Tuberculosis (TB) YES NO

Bleeding Problems YES NO

Anemia YES NO

Received blood transfusions YES NO

If yes, when? _____
How many? _____

Tobacco Use YES NO

What kind? _____
How much? _____
How often? _____

Alcohol Use YES NO

What kind? _____
How much? _____
How often? _____

Drug Use YES NO

What kind? _____
How much? _____
How often? _____

Tattoos YES NO

If yes, professionally done? YES NO
If yes, when? _____

Have you ever been seen by a psychiatrist? YES NO

If you answered yes to any of the questions on this page, please describe your illness/condition. Include number of times you were treated and/or how long you were ill.

_____
_____
_____
_____

Have you ever had surgery? YES NO

If yes, please describe and give date(s):

_____
_____
_____
_____

Do you take any prescription medications? YES NO

Do you take any over-the-counter medications? YES NO

Do you take any herbal supplements? YES NO

If yes to the above, please list all medications, over-the-counter medications, and herbal supplements you are taking. Include dosage and frequency of use.

_____
_____
_____
_____
_____
_____
_____
_____

Submitted by _____ Date: _____ Time: _____

This information will be reviewed by the Transplant Team. The Transplant Nurse Coordinator will call you with more information about the next step. Please feel free to call us at 248-551-1033 or 1-800-253-5592 extension 1, if you have any questions.

The enclosed booklet will provide you with general information about being a potential living organ donor. Please read the information carefully. If you have any questions, please call the transplant center.

Thank you,
Beaumont Transplant Team

Donor Consent for Initial Blood Work

Please review the following information and sign below to acknowledge that you have been informed about the living donor process and wish to proceed with initial blood work testing to determine your compatibility with potential recipient.

- I have read "*Your Kidney Donation Decision: What You Need to Know*" information booklet.
- I am willing to donate free from inducement or coercion.
- I understand that it is a federal crime for any person to knowingly acquire, obtain or otherwise transfer any human organ for valuable consideration (i.e., anything of value such as cash, property, vacations, etc.).
- I understand that I may decline to donate at any time. If I decline to donate, I understand that it will be done in a secure and confidential manner.
- I understand that Beaumont's Transplant Team may refuse to accept me as a living donor. If so, I can be screened at another center that may have different selection standards.
- In the event that I go through kidney donation surgery, I commit to follow-up at the transplant clinic at **6 months, 1 year, and 2 years** post operatively so that my kidney function can be checked to monitor my wellbeing and to allow the transplant center to conform to United Network for Organ Sharing (UNOS) reporting regulations (*alternative arrangements will be made for those patients with special circumstances; i.e., out-of-town donors, to fulfill this requirement).*
- I am aware that some of my personal information will be made available to UNOS and some test results will be kept permanently in the recipient's medical record.
- Beaumont Health System will provide confidentiality for me and the potential recipient.
- I consent to initial blood work testing to determine compatibility with recipient as the first step in the donation process.

_____	_____	_____
Signature of Living Donor Candidate	Date	Time
_____	_____	_____
Printed Name of Living Donor Candidate	Date	Time