PRISMA HEALTH

Date completed:_____

Living Donor Questionnaire

Thank you for your interest in living organ donation. To begin the referral process please complete this survey and return to the living donor coordinator. Instructions are located on the last page.

Once the form is received, the living donor advocate will contact you to answer any questions and to facilitate the review process.

Name:_____Date of Birth: _____

Address:_____City:_____State:____Zip:_____

Phone number:_____Email: _____

SSN:_____-_____-_____ Gender: [ ]Male [ ]Female Race:_____

Preferred Contact: [ ] Email [ ]Phone Prisma MRN:_____

Do you currently have health insurance? □ Yes □ No

Primary Care Physician: _____

Primary Care Physician Address & Phone Number: _____

_____

Transplant Recipient's Name:_____Date of Birth: _____

Have you met the intended recipient? □ Yes □ No

Does your recipient know that you are considering donation? □ Yes □ No

What is your relationship to the recipient?

[ ] Family (relationship):_____[ ] Friend [ ] Co-worker [ ] None [ ] Other: _____

[ ] I do not have a specific person in mind

What is your height_____and weight_____lbs/kg Blood type _____

Have you ever been told you have high blood pressure? □ Yes □ No

Have you ever been told you have diabetes? □ Yes □ No

How many, if any, family members are diabetic? _____

Have you ever been told you have arthritis? □ Yes □ No

Have you ever been told you have lupus? □ Yes □ No

If Female, have you ever been pregnant? □ Yes □ No

How many pregnancies? _____

Any gestational diabetes or pre-eclampsia □ Yes □ No

Have you ever been told you have kidney problems? □ Yes □ No

Have you ever had a kidney stone? □ Yes □ No

PRISMA HEALTH

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Have you had a heart attack in the past? □ Yes □ No

Have you ever had heart surgery or stents? □ Yes □ No

Have you ever been told that you had cancer? □ Yes □ No

Type of cancer/treatment: _____

Have you had any abdominal surgeries in the past? □ Yes □ No

If so, what type of surgery? _____

Have you ever been hospitalized for a psychiatric condition? □ Yes □ No

Have you ever attempted to harm yourself or others? □ Yes □ No

Do you currently use tobacco products? □ Yes □ No

If former smoker, for how many years and how much? _____

Do you drink alcohol? □ Yes □ No

If so, how much and how often?_____

In the past year have you: Used any recreational or illegal drugs? □ Yes □ No

Or used a prescription medication for a non-medical purpose? □ Yes □ No

Have you had: Mammogram?_____Pap Smear?_____Colonoscopy?_____PSA?_____

Are you willing to accept blood products?_____

Are there any other health problems you think we should be aware of?_____

_____

Please list all medications [including over the counter medications, supplements, and herbs]

Medication	Dose	Frequency

Signature:_____Date: _____

Please email, fax or mail back to: **Living Donor Kidney Program**
890 W. Faris Road, Suite 510
Greenville SC 29605

Main Office: 864-455-1770
Fax: 864-455-1775