University Transplant Center
Experts On Life.

A University Health System & UT Health Science Center Partnership | San Antonio

Date: _____

Attempt 1:_____
Attempt 2:_____

TRANSPLANT Living Donor Initial Screen

Recipient Name: _____ MRN: _____

Recipient Coord: _____ Interviewer: _____ Date: _____

Preliminary Screen:

Potential Donor Name: _____ DOB: _____

Address: _____ City/State: _____ Zip _____

Phone Number: _____ Email Address: _____

Relationship to recipient: _____

Ht: _____ Wt: _____ BMI: _____

Blood pressure x2: #1_____ #2_____

Medical coverage: ☐Yes or ☐ No

Past Medical History (Yes or No)

Diabetes…… ☐Yes or ☐No
Hypertension……☐Yes or ☐No
Stroke……☐Yes or ☐No
Cancer……☐Yes or ☐No
Recurrent UTI……☐Yes or ☐ No
Kidney trauma or injury……☐Yes or ☐No
Protein or blood in urine……☐Yes or ☐No
Other kidney disease……☐Yes or ☐No
Liver disease……☐Yes or ☐No
Kidney Stones……☐Yes or ☐No
Gestational Diabetes……☐Yes or ☐No
PIH-toxemia-preeclampsia……☐Yes or ☐No
Infectious disease: (HIV /Hep C /Hep B)...☐Yes or ☐No
Autoimmune: (Lupus / Rheumatoid arthritis / Ulcerative Colitis - Crohn's dz)……☐Yes or ☐No

Psychosocial History (Yes or No)

Depression-Anxiety……☐Yes or ☐No
Suicidal thoughts or attempts……☐Yes or ☐No
Bipolar disorder……☐Yes or ☐No
Psychiatric illness……☐Yes or ☐No
Drugs _____ ETOH _____ Smoking _____

Clear to proceed ☐	Declined ☐	Hold ☐

POTENTIAL LIVING DONOR SCREENING QUESTIONNAIRE

FOR OFFICE USE ONLY

Date of interview: _____ **Ht** _____ **Wt** _____ **BMI** _____ **1st BP** _____ **2nd BP** _____
ABO _____ **Chart Review By:** _____ **Eval Status:** ☐**Accept** ☐**Decline** ☐**Hold**
Recommendation: _____
Date of consult: _____ **Ht:** _____ **Wt:** _____ **BP**: _____ **BP:** _____ **P**: _____ **T:** _____ **O2:** _____
Recip Name/MRN: _____ **Relationship**: _____ **Ins:**_____
Dx: _____ **Status:** _____ **Coordinator**: _____

PERSONAL HISTORY

Name: _____ **DOB**: _____ **Age**: _____ **SS#:** _____

Race and Ethnicity_____ **Gender**_____ **Marital Status**:_____ **Spouse/significant other**:_____

Mailing address: _____ **City/State**: _____ **Zip**:_____

What are your living arrangements: _____ **Email address**:_____

Home phone: _____ **Cell**: _____ **Work**: _____

Emergency contact #: _____**US citizen**: _____ **If no, what is your status**: _____

Occupation: _____**Currently employed?** _____ **FT/PT?** _____

Level of education: _____ **Federal or State employee?** _____ **Active military/reservist**? _____

Do you have insurance? _____**What type of insurance do you have**: _____**Group #**: _____

Name of person you wish to donate to: _____

PRIMARY CARE PHYSICIAN

Physician Name: _____ **Phone #:** _____

Do you receive regular medical care? _____

MEDICAL HISTORY- Please explain any current or past conditions, problems, symptoms that apply to you.

Recent illness, fever, chills, night sweats, weight gain/loss? _____

Please explain:_____

Bruising, rashes, itching, skin cancer, suspicious lesions, other diseases of the skin? _____

Please explain: _____

Vision, hearing, speech, or throat problems? _____

Please explain: _____

Last dental exam: _____ Dental problems such as swollen/bleeding gums, use of dentures, partials? _____

Please explain: _____

High blood pressure, high cholesterol, Stroke, bleeding or blood clots, shortness of breath, palpitations, chest pain, swelling in arms or legs, murmur, heart disease, heart attack, circulation problems, vascular disease? _____

Please explain: _____

Asthma, lung disease, Cancer, chronic/productive cough, wheezing, pain with breathing, pneumonia, positive TB skin test/Tuberculosis?_____

Please explain:_____

Vomiting blood, rectal bleeding, acid reflux, heartburn, ulcers, ulcerative colitis, nausea, diarrhea, constipation, abdominal pain, colitis, colon polyps/tumors, Hepatitis, liver disease, Chron's disease? _____

Please explain: _____

Frequent urination, pain on urination, bladder/ urinary tract infection, blood in urine, kidney stones, kidney disease, prostate problems? _____

Please explain:_____

Muscle cramps, muscle aches, joint pain, swelling, back/neck pain, fatigue, Arthritis, Rheumatoid Arthritis, Lupus, Autoimmune Disorder? _____

Please explain:_____

Frequent headaches, migraine headaches, seizures/Epilepsy, numbness, paralysis, loss of consciousness, dizziness, tremors, or speech problems?_____

Please explain:_____

Depression, anxiety, suicidal thoughts/attempts, mood swings, constant crying, difficulty sleeping, mental illness? _____

Please explain:_____

Cold intolerance, heat intolerance, thyroid disorder, Diabetes?_____

Please explain: _____

Abnormal bruising, abnormal bleeding, anemia, high risk behavior (multiple sexual partners, homosexuality)AIDS/HIV? _____ Please explain: _____

Have you been in a country where an Ebola outbreak occurred within the past 21 days (Guinea, Liberia, Nigeria, Sierra Leone)? _____

Do you have any of the following symptoms: fever greater than 101.5F, severe headache, muscle pain, vomiting, diarrhea, abdominal pain, unexplained bleeding?_____

Contact with blood, other body fluids or human remains of a patient known or suspected to have Ebola? _____

Residence in or travel to an area where Ebola transmission is active in the past 21 days? _____

Direct handling of bats or non-human primates from disease endemic areas? _____

Please explain: _____

Have you been tested for TUBERCULOSIS –PPD/blood test hx? _____ PPD dates: _____ Result: _____

Tx w/INH or Rifampin? _____ For how long? _____

Have you been around family members (immediate/extended), co-workers, neighbors with TB? _____

Any TB symptoms (productive cough, hemoptysis, fevers, night sweats, unintentional weight loss?): _____

SOCIAL HISTORY

Do you have a history of being arrested, on probation, or in legal trouble**?** _____

Ever smoked? _____Age you started smoking: _____ Packs per day/month: _____ years smoked: _____

Any tobacco use? _____ What type?_____Frequency? _____

Do you drink alcohol: _____ Age you started drinking: _____ What type: _____

How often: _____ How many years: _____

Are you willing to quit smoking AND drinking for the purpose of donation? _____

Drug history: _____ Type of drug: _____ Last use: _____ When did you quit:_____ Shared needles: _____

Have you been in a program for drug/alcohol abuse: _____

Do you have tattoos? _____ How many: _____ Professional or homemade: _____ When were they done: _____

FEMALES

Pregnancies: _____ Miscarriages: _____ Abortions: _____ Cesarean Births: _____ Vaginal Births: _____

Did you have diabetes or high blood pressure when you were pregnant? _____

Were there any other complications during your pregnancy? _____

Post-partum depression _____ What type of birth control do you use? _____

Any problems with your menstrual cycle? ___ If yes, please explain: _____

Last menstrual cycle: _____Last pap smear: _____Results: _____Last mammogram: _____

Results: _____ PCOS, Chlamydia, STDs or other diseases: _____

FAMILY HISTORY-Give the following information about your immediate family

Mother: **Alive/Deceased** _____ **Age**: _____ **Health**:_____

Father: **Alive/Deceased** _____ **Age**: _____ **Health**: _____

# of Brothers: _____ **Alive/Deceased** _____ **Age(s)**: _____ **Health**: _____

# of Sisters _____ **Alive/Deceased** _____ **Age(s)**: _____ **Health**: _____

# of Sons _____ **Alive/Deceased** _____ **Age(s)**: _____ **Health**: _____

# of Daughters _____ **Alive/Deceased** _____ **Age(s)**:_____ **Health**: _____

ALLERGIES

Are you allergic to any drugs/food/latex/contrast? _____

What kind of reaction do you experience? _____

CURRENT MEDICATIONS- List all prescribed medications and over-the-counter medications			
Medication name	Dose	How often	Why do you take this

Have you ever had any problems with anesthesia? ____ If yes, please explain: _____

Have you ever had any blood transfusions? _____ If yes, please explain: _____

SURGICAL HISTORY- Please list below

DATE	PROCEDURE/OPERATION

ADDITIONAL INFORMATION

Are you willing to lose weight, if needed? _____

Are you willing to continue a healthy lifestyle (healthy diet, weight control, exercise and have routine medical care/screening) for the rest of your life after donation? _____

Who will help you while you recover from surgery if needed? _____

Are you willing to have all required testing for living donation? _____

Donor testing and surgery are covered by the recipient's insurance. Do you understand that post donor follow up, travel, time off from work and lodging expenses are NOT covered by the recipient's insurance? _____

Do you give permission for members of the transplant team to discuss the results of compatibility testing with the recipient and the recipient's referring physician? _____

Why do you want to donate?

_____

_____

What questions do you have regarding donation?

_____

_____

_____

_____ _____

Signature **Date**