



Date: \_\_\_\_\_

## DONOR PERSONAL HISTORY

<b>Name</b> <i>(Last, First, M.I.):</i>		<b>DOB:</b>	
<b>Preferred Name:</b>		<b>Maiden Name:</b>	
<b>Address:</b>		<b>SSN:</b>	
<b>Phone number:</b>		<b>Work phone:</b>	
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<b>Height:</b>	<b>Weight:</b>
Spouse/Significant Other's Name (if applicable):		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	
<b>Race/Ethnicity:</b> <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Asian <input type="checkbox"/> Other _____			
<b>Citizenship:</b> <input type="checkbox"/> US Citizen <input type="checkbox"/> US Resident/Non-US Citizen <input type="checkbox"/> Non-US Citizen/Non-US Resident			
<b>Primary Care Physician (PCP):</b>			
<b>PCP Address:</b>		<b>Phone:</b>	<b>Fax:</b>
<b>Potential Recipient Name:</b>			
<b>Relationship to Recipient:</b>		<b>Are you biologically related?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

### HEALTH HISTORY

<b>Blood Type (if known):</b> <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O				
<b>Do you currently or have you ever had any of the following conditions?</b>				
	Yes	No	If yes, please explain (date of diagnosis, type, frequency, etc.)	Is there any family history of this condition?
Diabetes				
High Blood Pressure				
Heart Condition/Chest Pain				
Kidney Condition				
Kidney Stones				
Kidney/Bladder Infections				
Lung Condition				
Chronic Pain Condition				
Cancer (including skin)				
Suicidal Thoughts/Attempts				
Psychiatric Illness				
Seizure Disorder				

**List any other medical problems that your doctor has diagnosed:**

**Surgical History (Please list all major surgical procedures)**

Year	Surgical Procedure



Health Maintenance Testing (Please list dates of most recent testing. All age-appropriate testing will need to be up to date to be approved as a donor.)	
Year	Test (ex. Colonoscopy, pap smear, mammogram)

**List ALL your prescribed medications and over-the-counter medications INCLUDING vitamins and supplements**

Name the Drug	Strength	Frequency Taken

**Allergies to medications**

Name the Drug	Reaction You Had

<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind (ex. wine, beer, liquor)?			
	How many drinks per week?			
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you willing to quit?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes	How much per day? _____	<input type="checkbox"/> Chew	<input type="checkbox"/> Pipe or Cigars
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
<b>Drugs</b>	Do you currently use marijuana?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is your marijuana use related to a medical condition?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you currently use other recreational drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Other</b>	Do you live alone?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have access to transportation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Choose what best describes your functional status:			
	<input type="checkbox"/> 100% - Normal, no complaints, no evidence of disease			
	<input type="checkbox"/> 90% - Able to carry on normal activity, minor symptoms of disease			
	<input type="checkbox"/> 80% - Able to carry on normal activity with some effort, some symptoms of disease			
	<input type="checkbox"/> 70% or below – Significant disease symptoms, requires help for normal activity			
	Choose what best describes your physical capacity:			
	<input type="checkbox"/> No mobility limitations			
	<input type="checkbox"/> Limited mobility			
<input type="checkbox"/> Wheelchair bound				
Do you perceive any barriers to you donating?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:				



Are there people in your life who support your decision to donate and are able to help you during recovery?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have someone who could accompany you to your donor evaluation day?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any children?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how many?		Ages:	
Highest level of education completed? <input type="checkbox"/> Grade school (0-8) <input type="checkbox"/> High school (9-12) <input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctoral degree			
Have you traveled out of the country in the last 2 years?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Where and when?			
Are you employed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Full time or part time?		What is your occupation?	
Are you a student?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Full time or part time?			
Are you retired?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had legal issues with law enforcement?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you on probation/parole?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have health insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you receiving disability benefits?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Living Donor Criteria: The following criteria must be met in order to be a living donor.**

Note: these are the main criteria for donation but there may be other conditions or situations that could rule out potential donors. The transplant team also has the discretion to accept a donor outside of these criteria in certain situations.

- Over age 18
- Absence of kidney stones or kidney disease
- Stable cardiac and pulmonary status
- Absence of high blood pressure and diabetes
- Complete smoking cessation for 3 months prior to donor surgery
- No chronic pain requiring NSAID treatment
- BMI (Body Mass Index) less than 35; less than 30 is recommended
- No evidence of chronic or active infection (i.e. HIV)
- Donation is voluntary, free of coercion
- Willingness to do follow-up testing at six months, one year and two years after donation
- Not pregnant
- Negative age and gender appropriate screens
- Adequate social and financial resources
- Stable psychiatric and emotional status
- No chronic alcohol or substance abuse dependency
- Realistic expectation of recipient's benefit from transplant
- No active or recent cancer
- Capable of making an informed decision
- No bleeding or thrombosis disorders
- Must be willing to accept blood transfusion in event of bleeding

**Return your donor forms by mail:** Trinity Health Saint Mary's  
Kidney Transplant Program  
Attn: Living Donor Team  
200 Jefferson SE  
Grand Rapids, MI 49503

By fax: 616-685-8979 Attn: Living Donor Team

By email: donor@trinity-health.org

