Atrium Health

Potential Living Donor Referral Form

Demographic Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Best Time to Contact: Morning (8 a.m. to noon) ☐ Afternoon (noon to 4 p.m.) (circle one) ☐

Email Address: _____

Occupation: _____ Work Phone: _____

May we contact you at work: ☐ Yes ☐ No

US Citizen: ☐ Yes ☐ No

Social Security Number: _____ (for registration purposes only)

Marital Status: _____

Height: _____ Weight: _____ Race: _____ Sex: _____

Do you have children: ☐ Yes ☐ No If so, how many and ages: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Recipient Information

Recipient Name: _____RUTH AVA LYONS_____ Recipient Date of Birth: __6/21/56___

Relationship to Recipient: ☐ Family ☐ Friend ☐ Neighbor ☐ Coworker ☐ Other/None

Family Detail (child, sibling, spouse, etc.)

Medical History

Primary Care Provider Name and Address: _____

Primary Care Provider Phone Number: _____

Do you currently have health insurance? ☐ Yes ☐ No

Allergies (medication/food): _____

Are you allergic to Latex? ☐ Yes ☐ No

Are you allergic to IV contrast or Shellfish? ☐ Yes ☐ No

MEDICAL HISTORY

Medical (SELF)	Yes	No	Medical (FAMILY)	Yes	No	Relationship
High Blood Pressure	◯	◯	High Blood Pressure	◯	◯	
Diabetes	◯	◯	Diabetes	◯	◯	
Heart Disease	◯	◯	Heart Disease	◯	◯	
Cancer: _____type	◯	◯	Cancer: _____type	◯	◯	
When: _____	◯	◯		◯	◯	
Melanoma: _____	◯	◯		◯	◯	
Lung Issues	◯	◯	Lung Issues	◯	◯	
Tuberculosis/Positive TB Skin	◯	◯	Tuberculosis/Positive TB Skin	◯	◯	
Anemia	◯	◯	Anemia	◯	◯	
Kidney Stone: year _____	◯	◯	Kidney Stone: year _____	◯	◯	
Migraines/Chronic Headaches	◯	◯	Migraines/Chronic Headaches	◯	◯	
Seizures	◯	◯	Seizures	◯	◯	
Bladder Infection	◯	◯	Bladder Infection	◯	◯	
Gynecological Issues	◯	◯	Gynecological Issues	◯	◯	
Lupus	◯	◯	Lupus	◯	◯	
Dizziness/Memory Loss	◯	◯	Dizziness/Memory Loss	◯	◯	
Stomach/Intestine Issues	◯	◯	Stomach/Intestine Issues	◯	◯	
Herpes	◯	◯	Herpes	◯	◯	
Prostate Issues	◯	◯	Prostate Issues	◯	◯	

Psychosocial	Yes	No
Body Piercings/Tattoos	◯	◯
Do you smoke? If so,	◯	◯
how many packs per day. ___		
Alcohol Use:	◯	◯
_____ amount per day		
_____ amount per week		
_____ amount per month		
History of Drug Use	◯	◯
History of Depression	◯	◯
History of Bulimia/Anorexia	◯	◯

Office Notes:

Please list your medications and their dosages: (Use additional paper, if necessary)

Medication	Dosage	How often?

Please list all your surgeries and dates they occurred: (Use additional paper, if necessary)

Surgery	Date	Location

Have you traveled outside of the country in the past 6 months? If yes, where? _____

_____

Please have blood pressure check and record here _____/_____

Date: _____ Taken where: _____

If your reading is greater than 140/80, please provide an additional reading _____/_____

What is your desired timeframe for donation? ☐ 3-6 months ☐ 6 months - 1 year ☐ greater than 1 year

How did you hear about being a living donor? ☐ Family ☐ Friends ☐ Community

☐ Social media, please specify ☐ Other, please specify _____

Current National and Program specific transplant recipient outcomes are updated every six months and the data can be found on the Scientific Registry of Transplant Recipient at srtr.org. There currently are no national or center specific outcomes for living donors calculated by the Scientific Registry of Transplant Recipient. If you have questions about this data or how to use the website, you can discuss this with your living donor team member.

I have read and understand the patient educational material presented to me for potential living donors. I have answered these questions to the best of my ability and without coercion. I understand that I can change my mind at any time about being a living donor. I would like to proceed with my evaluation if I am an appropriate candidate.

At this time, my willingness to donate on a scale from 1-10 is 10.

Signature: _____ Date: _____

For Office Use Only

Date Received: _____ Assigned to: _____

Reviewed by: _____ BMI _____ / MRN _____

ILDA Team Member Signature: DATE: _____

_____

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