Trinity Health

Date:

DONOR PERSONAL HISTORY

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

HEALTH HISTORY

Blood Type (if known): ☐ **A** ☐ **B** ☐ **AB** ☐ **O**

Do you currently or have you ever had any of the following conditions?

	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	

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind (ex. wine, beer, liquor)?		
	How many drinks per week?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	If yes, are you willing to quit?	☐ Yes	☐ No
	☐ Cigarettes How much per day?______________ ☐ Chew ☐ Pipe or Cigars ☐ Vape		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use marijuana?	☐ Yes	☐ No
	Is your marijuana use related to a medical condition?	☐ Yes	☐ No
	Do you currently use other recreational drugs?	☐ Yes	☐ No
Other	Do you live alone?	☐ Yes	☐ No
	Do you have access to transportation?	☐ Yes	☐ No
	Choose what best describes your functional status: ☐ 100% - Normal, no complaints, no evidence of disease ☐ 90% - Able to carry on normal activity, minor symptoms of disease ☐ 80% - Able to carry on normal activity with some effort, some symptoms of disease ☐ 70% or below – Significant disease symptoms, requires help for normal activity		
	Choose what best describes your physical capacity: ☐ No mobility limitations ☐ Limited mobility ☐ Wheelchair bound		
	Do you perceive any barriers to you donating?	☐ Yes	☐ 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?	☐ Yes	☐ No
Do you have someone who could accompany you to your donor evaluation day?	☐ Yes	☐ No
Do you have any children?	☐ Yes	☐ No
If yes, how many?	Ages:	
Highest level of education completed? ☐ Grade school (0-8) ☐ High school (9-12) ☐ Some college ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctoral degree		
Have you traveled out of the country in the last 2 years?	☐ Yes	☐ No
Where and when?		
Are you employed?	☐ Yes	☐ No
Full time or part time? What is your occupation?		
Are you a student?	☐ Yes	☐ No
Full time or part time?		
Are you retired?	☐ Yes	☐ No
Have you had legal issues with law enforcement?	☐ Yes	☐ No
Are you on probation/parole?	☐ Yes	☐ No
Do you have health insurance?	☐ Yes	☐ No
Are you receiving disability benefits?	☐ Yes	☐ 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.

- Age 18-65
- 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