Penn Medicine

Hospital of the University of Pennsylvania — Penn Transplant Institute

Living Donor Questionnaire – Short Form

Thank you for your interest in living organ donation. To begin the referral process please complete this survey and return to the living donor team of your choice. Instructions found on last page.

Name: _____ Date of Birth: _____

Address: _____ City:_____ State: ___ Zip:_____

Phone number: _____ Email: _____

Preferred Contact: [] Email []Phone Gender: []Male []Female Race:_____

Do you currently have health insurance? □ Yes □ No

Primary Care Physician: _____

Primary Care Physician Address & Phone Number: _____

_____

Are you interested in donating? □ Kidney □ Liver □ Both

What is your relationship to the recipient?

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

[] I do not have a specific person in mind

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 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 that you have kidney problems? □ Yes □ No

Have you ever had kidney stones? □ Yes □ No

If so, how was the kidney stone treated? _____

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

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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

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

Do you currently use tobacco products? □ Yes □ No

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

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

Medication	Dose	Frequency

Signature: _____ Date: _____

Instructions for Form Return:

	Kidney Donor Program	Liver Donor Program
Email (preferred)	kidneylivingdonorteam@uphs.upenn.edu	livingliverdonor@uphs.upenn.edu
Fax	215-243-2354	215-662-2244
Mail	Kidney Donor Program, PCAM 2 West 3400 Civic Center Blvd Philadelphia, PA 19104	Liver Donor Program, Hospital of the University of Pennsylvania 3400 Spruce Street, 2nd floor Dulles Philadelphia, PA 19104
Phone	215-662-6200	215-349-8220