Ascension Sacred Heart

DONOR HEALTH HISTORY/CONSENT FOR COMPATIBILITY TESTING

I would like to be a kidney donor for: _____

My relationship to recipient: _____

Donor Name: _____

Street Address: _____

City: _____State: _____Zip Code:_____

Phone number: _____ Best time to reach me: _____

Email address: _____

DOB: _____Sex: _____ Race: _____

Social Security Number:_____

Marital Status: _____

Age(s) of children (if applicable): _____

Emergency contact name: _____

Relationship: _____ Phone: _____

Primary Language: English Spanish Other: _____

Highest level of education completed: _____

Place of employment:_____ Full-time Part-time (circle one)

Occupation: _____

US Citizen: Yes _____ No _____ (circle one)

Family physician: _____ Phone: _____

Street address: _____

City: _____State: _____ Zip code:_____

Medical History

Height: _____ Weight:_____ ABO Blood Type (if known): _____

Most recent physical exam (month/year): _____

If female, date of last gyn exam, pap, and mammogram:

_____

Date of last colonoscopy (45 years and older): _____

Current health insurance? Yes No (circle one)

Allergies to drug, food and/or Iodine: _____

Have you ever had a reaction to eating shellfish? Yes No (circle one)

Have you ever received x-ray dye? Yes No (circle one)

Circle **Yes** or **No** to any of the medical conditions below that you have now, or have had in the past.

High Blood Pressure	Yes	No	Stroke/Loss of consciousness	Yes	No
Bladder/Kidney infection	Yes	No	Lung Problems/Asthma	Yes	No
Kidney Stones	Yes	No	Stomach/Liver Problems	Yes	No
Diabetes	Yes	No	Back/Bone/Muscle Injury	Yes	No
Anemia/Bleeding Problems	Yes	No	Depression/Emotional Problems	Yes	No
Heart Problems/Murmurs	Yes	No	Cancer	Yes	No

If you circled **YES** to any of the above, please explain when you were ill and the treatment received.

_____

_____

List all surgeries, the approximate date(s) and reason for the surgery:

Date	Type of Surgery	Reason for Surgery

List each medication you currently take, the dose/frequency, and the reason for taking the medication.

Medication	Dose / Frequency	Reason Taking Medication

If you use tobacco, how much/ how often/ and for how long?

_____

If you drink alcohol, how much/ how often/ and for how long?

_____

If you use any other drugs or substances, what type and how often?

_____

Family History

List any blood relatives that had any of the following medical conditions:

Condition	**Relative**
Anemia (including sickle cell)	
Cancer / Leukemia	
Diabetes	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Kidney Stones	
Other	

Describe the present condition of your immediate family members:

Relative	Present Age or Age at Death	If living, state of health (good, fair, poor). If deceased, cause of death.
Father		
Mother		
Brother		
Sister		

Son		
Daughter		
Maternal grandfather		
Maternal grandmother		
Paternal grandfather		
Paternal grandmother		

I have read the Living Donor pamphlet included with this form: **Yes** **No**

Please circle the number that best rates your willingness to donate a kidney:

Not willing 1 2 3 4 5 6 7 8 9 10 Very Willing

Comments or concerns you may have about becoming a kidney donor:

_____

_____

Consent for Compatibility Testing

I consent to have my blood tested for compatibility to my intended recipient. I understand the results will be provided to me by a representative of Ascension Sacred Heart (ASH) Kidney Transplant Clinic, and that no information about my testing is provided to the recipient by ASH Kidney Transplant Clinic.

Signature:_____ Date: _____

Ascension Sacred Heart Hospital
Kidney Transplant Center
5149 North 9th Ave Suite 246
Pensacola, FL 32504
Phone: 850-416-1080
Fax: 850-416-1075