Dear Potential Donor,

Donating one of your kidneys to another person can be a priceless gift, but it must be done with serious consideration. SUNY Downstate Medical Center is committed to your safety and ensuring you are fully informed of the risks and benefits of living donation.

Please take a moment to complete the enclosed questionnaire. Your honesty is very important in establishing risk for yourself as well as your potential recipient.

We will review your responses to make sure there are no obvious reasons preventing you from becoming a living donor. If you are believed to be a suitable candidate for donation, a comprehensive evaluation will be arranged which will include blood typing to determine your match to the potential recipient.

It is important that you understand that at no point should you feel obligated to complete an evaluation. We expect that all our live donors are donating at their own free will.

**ALL INFORMATION OBTAINED IS CONFIDENTIAL.**

Should you have any questions or concerns, please do not hesitate to contact our center for organ donation at 888-705-9323 or 718-270-3168/3169.

Sincerely,

Living Donor Team

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**DATE** \_\_\_\_\_\_\_\_\_\_\_

**DONOR NAME:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: First Name:

**DATE OF BIRTH AGE**

MM DD YYYY

**GENDER RACE/ETHNICITY**

 Male Asian

 Female Black/African-American

 Non-binary gender Hispanic/Latino

 White

 Other (specify) ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** *(enter full address to include Apt/City/State/Zip)*

**Home Phone:** **Cell Phone:** **Other**:

**E-mail:** **Height**   **Weight**

**BLOOD TYPE (if known)**

 A B AB O Unknown

**RECIPIENT NAME**

Last Name First Name

Date of Birth (if known) Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CITIZENSHIP MARITAL STATUS**

 U.S Citizen Single

 Resident Alien Married

 Non-Resident Alien Divorced

 Other­­­­­­­­­ (specify) \_\_\_\_\_\_\_\_\_\_\_ Separated

 Life-Partner

 Widow

**PRIMARY LANGUAGE SPOKEN**

**ARE YOU CURENTLY EMPLOYED?**

 Yes

 No

**EMPLOYMENT STATUS**

 Full-time

 Part-time

 Self-employed

 Student

 Unemployed

**DONOR INSURANCE INFORMATION:** Do you have medical insurance coverage?

 Yes

 No

**PRIMARY CARE PHYSICIAN INFORMATION:** *please enter name and phone number or indicate “None”*

**CONTACT INFORMATION:** *In case your address or telephone number changes in the future, please list a contact that we may call to get updated information for you (enter name and phone number below)*

**HAVE YOU BEEN DIAGNOSED WITH COVID-19?**

 Yes Were you hospitalized and how long?) Yes ­­­\_\_\_\_\_\_\_\_\_\_\_\_

 No

 No

**COVID-19 VACCINATION STATUS**

Fully vaccinated

 Partially vaccinated

Not yet vaccinated but intending to get vaccinated

 Not intending to get vaccinated

**HAVE YOU TRAVELED OUTSIDE OF THE UNITED STATES IN THE LAST 3 YEARS?**

 Yes Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_

 No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:** Have you had any of the following conditions?

 Yes No

Bleeding problems

Cancer

Chronic Infections

Diabetes

Hepatitis B or C

 Yes No

High Blood Pressure

High Cholesterol

HIV

History of Kidney Disease

Kidney Stones

Pregnancies

**IF YES TO HISTORY OF CANCER,** *please specify below*

 Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When Diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YES TO PREGNANCIES,** *please specify below*

Did you develop gestational diabetes? \_\_\_\_\_\_\_\_\_\_

Did you develop gestatinal high blood pressure? \_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU HAD A BLOOD PRESSURE CHECK IN THE LAST 6 MONTHS?**

 Yes What was your blood pressure reading? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 No

**CURRENT/PAST MEDICAL PROBLEMS/ILLNESS:** *If none, please indicate “None”*

**SURGERIES/DATE:** *If none, please indicate “None”*

**CURRENT MEDICATIONS** *(including dosage, over the counter, herbals, and supplements)*

*If none, please indicate “None”*

**ALLERGIES TO ANY FOOD OR MEDICATION:** *If none, please indicate “None”*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE USE HISTORY**

**Cigarette Smoking Status**

 Never

 Current How many Years? ­\_\_\_\_\_\_\_\_\_\_\_\_\_

 Quit How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cigarette Use**

 Light (<10 cigarettes/day)

 Moderate (11-20 cigarettes/day)

 Heavy (>20 cigarettes/day)

 None

**Alcohol Status**

 Never

 Occasionally

**Alcohol Use**

*How often do you have a beverage containing alcohol?*

 Never

 Monthly or less

 2-4 times per month

 2-3 times per week

 4 or more times per week

**Other drugs used** (past/current)

 None

 Cocaine

 Heroin

 Marijuana

 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH**

**WHERE YOU EVER DIAGNOSED WITH A MENTAL ILLNESS?**

 Yes

 No

**HAVE YOU EVER RECEIVED COUNSELING OR TREATMENT WITH MEDICATION?**

 Yes

 No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIOLOGICAL FAMILY MEDICAL HISTORY**

Please indicate if parents/siblings are alive or deceased

 Alive Deceased N/A

Mother

Father

Sister(s)

Brother(s)

**Please Indicate if parents/siblings have a history of:**

 Mother Father Sister(s) Brother(s)

Bleeding Problems

Cancer

Chronic Infections

Diabetes

High Blood Pressure

Kidney Disease

Kidney Stones

Lupus

Sickle Cell Anemia

Other

None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DONOR ACKNOWLEDGMENT**

I acknowledge by completing this questionnaire, that I am donating of my own free will. I understand that I am not obligated to complete the evaluation and have the option to withdraw my consent at any time during the process.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date