Ohio State Comprehensive Transplant Center

LIVING DONOR ASSESSMENT FORM

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

FOR OFFICE USE ONLY

FORM RECEIVED: | TRANSPLANT #: | PRA:

RECIPIENT'S MRN: | RECIPIENT'S BLOOD TYPE:

RECIPIENT'S DISEASE:

RECIPIENT'S STATUS: | TRANSFUSION HISTORY:

Please complete all sections and submit this form along with a copy of your blood type to the Pre-Transplant Office at the Ohio State Comprehensive Transplant Center.

INFORMATION ABOUT YOUR RECIPIENT

Recipient's name to whom you wish to direct your organ donation:

Recipient's Date of Birth: | Your relationship to the Recipient:

Have you met the Recipient? ☐ Yes ☐ No | How did you learn of the Recipient's need for an organ transplant?

Is your Recipient a patient at: ☐ Ohio State Wexner Medical Center ☐ Nationwide Children's Hospital

YOUR PERSONAL INFORMATION

Your Legal Name: | **Date:**

Preferred Name (if applicable): | Maiden Name:

Social Security Number: | Date of Birth: | Age:

Blood Type: ☐ A ☐ B ☐ AB ☐ O | I have attached a copy of my blood type: ☐

Which organ do you wish to donate? ☐ **Kidney** ☐ **Liver** | **OFFICE USE ONLY – MRN:**

Sex: ☐ Male ☐ Female | Height: | Weight: | **OFFICE USE ONLY – BMI:**

Country of Birth: | Citizenship: | Race/Ethnicity:

Street Address:

City: | State: | Zip:

Provide all applicable phone numbers, check the primary number:

☐ Home Phone: | ☐ Cell Phone: | ☐ Work Phone:

Email Address: | Marital Status:

Primary Doctor: | Primary Care Phone:

With whom may we share appointments and health information?

Revised: 3/1/2021

Legal Name: _____ **Date:** _____

DONATION INTEREST

If considering kidney donation, are you interested in Kidney Paired Exchange with your recipient if you are not compatible match?	☐ Yes ☐ No
Have you discussed your wish to donate with the intended recipient?	☐ Yes ☐ No
Have you discussed your wish to donate with your family / friends?	☐ Yes ☐ No
Why do you wish to donate?	

MEDICAL HISTORY

These questions are used to gather important information about your health and lifestyle that might impact on your potential to become a living donor. This information will be used by the health care professionals on our team to determine your overall well-being. All information on this questionnaire is kept strictly confidential.
Please provide details and dates for anything marked "Yes".

GENERAL HEALTH		
1.	**Have you ever had any abdominal surgery?**	☐ Yes ☐ No
	• If yes, what type, when?	
	• Name of Hospital:	
2.	**Have you ever had any other surgery?**	☐ Yes ☐ No
	• If yes, what type, when?	
	• Name of Hospital:	
3.	**Did you have any problems after surgery/anesthetic?**	☐ Yes ☐ No
	• If yes, what were the problems?	
4.	**Have you had any hospitalization for other reasons?**	☐ Yes ☐ No
	• If yes, when and why?	
	• Name of Hospital:	
5.	**Do you routinely take any medications (including prescriptions, over the counter, vitamins and herbal supplements)?**	☐ Yes ☐ No
	• If yes, list:	
6.	**Do you have allergies (drug or food)?**	☐ Yes ☐ No
	• If yes, to what?	
	• If yes, what type of reaction and symptoms do you have?	
	• If yes, do you carry an EpiPen?	☐ Yes ☐ No
7.	**Do have allergies to iodine, contrast dye, latex, shellfish?**	☐ Yes ☐ No

Legal Name: _____ **Date:** _____

8.	**Do you have Arthritis?**	☐ **Yes** ☐ **No**
	• If yes, what is your current treatment?	
9.	**Do you currently smoke or have you ever smoked?**	☐ **Yes** ☐ **No**
	• If yes, what (cigarettes, pipe, cigars)?	
	• How many per day? / For How Long: / Years?	
	• If you have quit, when did you quit?	
10.	**Do you drink alcohol?**	☐ **Yes** ☐ **No**
	• How many drinks per week? (1 drink = 1 bottle of beer, 1 glass of wine or 1-½ oz of spirits)	
	• For how long?	
	• Have you ever had treatment for alcohol abuse / dependency?	☐ **Yes** ☐ **No**
	• If yes, what treatment and when?	
11.	**Do you currently use or have you ever used nonmedical or recreational/ street drugs (ingested, inhaled, subcutaneous, intramuscular or intravenous drugs e.g. LSD, marijuana, hash, cocaine)?**	☐ **Yes** ☐ **No**
	• If yes, what and when?	
	• Have you ever had treatment for this?	☐ **Yes** ☐ **No**
	• If yes, what treatment and when?	
12.	**Do you have a history of intravenous (IV) drug use?**	☐ **Yes** ☐ **No**
	• If yes, when?	
13.	**Have you had any recent unexplained weight loss?**	☐ **Yes** ☐ **No**
	• If yes, explain:	

LIVER HEALTH

14.	**Have you ever had jaundice (yellow skin)?**	☐ **Yes** ☐ **No**
	• If yes, when?	
15.	**Have you ever had a liver problem?**	☐ **Yes** ☐ **No**
	• If yes, what type, when?	
16.	**Is there a family history of liver problems?**	☐ **Yes** ☐ **No**
	• If yes, what disease?	

CANCER HISTORY

17.	**Have you had cancer?**	☐ **Yes** ☐ **No**
	• If yes, type?	
	• When?	
	• Treatment: ☐ Radiation ☐ Chemo ☐ Surgery ☐ Other:	
18.	**Do you have a family history of cancer?**	☐ **Yes** ☐ **No**
	• If yes, who?	
	• What type of cancer?	

Legal Name: _____ **Date:** _____

INFECTION RISKS:

19.	**Have you ever received a blood transfusion or other blood product?**	☐ **Yes** ☐ **No**
	• If yes, type?	
	• When?	
	• Will you accept blood products if necessary?	☐ **Yes** ☐ **No**
20.	**In the past month have you had a tattoo, ear piercing or body piercing in which sterile procedures were not used (e.g. contaminated instruments and/or ink were used or shared instruments that had not been sterilized between uses were used)?**	☐ **Yes** ☐ **No**
	• If yes, what?	
	• When?	
21.	**Do you have a chronic infection of any type?**	☐ **Yes** ☐ **No**
	• If yes, what type, when?	
22.	**Do you or have you ever had Methicillin-Resistant Staphylococcus Aureus (MRSA)?**	☐ **Yes** ☐ **No**
23.	**Do you have or have you ever had any history of hepatitis?**	☐ **Yes** ☐ **No**
	• If yes, what type, when?	
24.	**Do you have or have you ever had any history of syphilis?**	☐ **Yes** ☐ **No**
	• If yes, what type, when?	
25.	**In the past month have you had close contact with another person having hepatitis (e.g. living in the same household, where sharing of kitchen and bathroom facilities occurs regularly?)**	☐ **Yes** ☐ **No**
26.	**Have you been treated for any infection in the past month?**	☐ **Yes** ☐ **No**
	• If yes, what?	
	• When?	
27.	**Have you ever been diagnosed with HIV?**	☐ **Yes** ☐ **No**
	• If yes, when?	
28.	**Have you had any vaccinations in the last 60 days?**	☐ **Yes** ☐ **No**
	• If yes, what type, when?	
29.	**Have you been vaccinated for Hepatitis B?**	☐ **Yes** ☐ **No**
	• If yes, when or at what age?	
30.	**Have you ever been suspected of having or been diagnosed with West Nile Virus?**	☐ **Yes** ☐ **No**
	• If yes, when?	
31.	**Have you ever been diagnosed with Valley Fever?**	☐ **Yes** ☐ **No**
	• If yes, when?	
32.	**Within the last 6 months have you traveled to southwest parts of the U.S. or anywhere outside of the U.S.?**	☐ **Yes** ☐ **No**
	• If yes, where and when?	

Legal Name: _____ **Date:** _____

33.	**TB SCREENING:**	
	• **Have you had close contact with a person known to have tuberculosis (TB)?**	☐ Yes ☐ No
	• If yes, when?	
	• **Have you ever had a positive TB skin test yourself?**	☐ Yes ☐ No
	• If yes, treatment?	
	• **Were you born or have lived outside of the U.S.?**	☐ Yes ☐ No
	• If yes, what country?	
	• **Have you recently traveled outside the U.S.?**	☐ Yes ☐ No
	• If yes, which country(s)? Dates?	
	• **Have you lived or worked in a homeless shelter/correctional facility/nursing home/hospital?**	☐ Yes ☐ No
	• If yes, which location(s)? Dates?	
	• **Have you had an abnormal chest X-ray or been told you have scars on your lungs?**	☐ Yes ☐ No
	• If yes, when?	
NEUROLOGICAL / PSYCHOLOGICAL		
34.	**Do you have a seizure disorder/epilepsy?**	☐ Yes ☐ No
	• Please provide details:	
35.	**Have you ever had a stroke/transient ischemic attack (TIA)?**	☐ Yes ☐ No
	• If yes when?	
36.	**Have you been diagnosed with or been investigated for any degenerative neurological diseases such as dementia, Alzheimer's, brain tumors, Parkinson's disease, Lou Gehrig's, Multiple Sclerosis (MS)?**	☐ Yes ☐ No
	• If yes, what and when?	
37.	**Do you have a mental health provider?**	☐ Yes ☐ No
	• If yes, provider's name?	
	• Provider's phone number:	
38.	**Have you ever had treatment for a psychiatric problem, suicidal thoughts or attempts, depression, anxiety, PTSD?**	☐ Yes ☐ No
	• If yes, when?	
	• Treatment:	
CARDIOVASCULAR		
39.	**Do you have a history of heart disease, heart attack or chest pain?**	☐ Yes ☐ No
	• If yes, elaborate:	
40.	**Have you ever had high blood pressure?**	☐ Yes ☐ No
	• If yes, date of diagnosis?	
	• Type of treatment:	
	• Length of treatment:	

Legal Name: _____ **Date:** _____

41.	**Have you ever had palpitations or been told that you have a heart arrhythmia?**				☐ **Yes** ☐ **No**
	• If yes, when?				
42.	**Do you have a pacemaker?**				☐ **Yes** ☐ **No**
43.	**Have you ever had a stress test or heart catheterization?**				☐ **Yes** ☐ **No**
	• If yes, when?		Where:		
HEMATOLOGY / BLOOD					
44.	**Do you and/or a family member have hemophilia or a clotting problem?**				☐ **Yes** ☐ **No**
	• If yes, what?				
45.	**Do you have a history of anemia?**				☐ **Yes** ☐ **No**
	• If yes, explain?				
46.	**Have you or any of your family members had a problem with excessive bleeding?**				☐ **Yes** ☐ **No**
	• If yes, when?				
47.	**Have you had excessive bleeding with any surgery or dental extractions?**				☐ **Yes** ☐ **No**
	• If yes, when?				
48.	**Have you and/or a family member ever had a blood clot in your lungs or legs?**				☐ **Yes** ☐ **No**
	• If yes, who?		Relationship:		
	• Location:		Date of Diagnosis:		
	• Treatment:				
RESPIRATORY					
49.	**Have you ever had any lung disease such as asthma or emphysema?**				☐ **Yes** ☐ **No**
	• If yes, what?				
	• When?				
	• Any treatment?				
50.	**Do you routinely use any inhalers or take medications to help your breathing?**				☐ **Yes** ☐ **No**
	• If yes, what?				
51.	**Do you have sleep apnea or use a CPAP machine?**				☐ **Yes** ☐ **No**
	• If yes, describe:				
GASTROINTESTINAL					
52.	**Do you have any stomach or intestinal problems, Crohns or colitis?**				☐ **Yes** ☐ **No**
	• If yes, what?				
53.	**Have you ever had a colonoscopy?**				☐ **Yes** ☐ **No**
	• If yes, when?				
	• Where was the procedure performed?				

Legal Name: _____ **Date:** _____

GENITOURINARY		
54.	**Have you ever had problems with your kidneys (such as infections or stones)?**	☐ Yes ☐ No
	• If yes, what type and when?	
55.	**Have you ever had any problems with your bladder (such as infections, incontinence, difficulty voiding or blood in your urine)?**	☐ Yes ☐ No
	• If yes, please describe:	
	• When?	
56.	**FOR MALES ONLY:**	
	• Do you have any problems related to an enlarged prostate?	☐ Yes ☐ No
	• If yes, what?	
57.	**FOR FEMALES ONLY:**	
	• Date of last menstrual period:	
	• Date of last PAP smear:	
	• Date of last mammogram:	
	• Have you ever had a gynecologic problem?	☐ Yes ☐ No
	• If yes, what?	
	• Have you had any pregnancies?	☐ Yes ☐ No
	• If yes, did you experience any problems with your pregnancies or deliveries (such as high blood pressure, toxemia or gestational diabetes/high blood sugar)?	☐ Yes ☐ No
	• If yes, please describe?	
	• List ages of your children:	
	• Are you currently trying to become pregnant or do you have plans for future pregnancies?	☐ Yes ☐ No
ENDOCRINE		
58.	**Do you have diabetes?**	☐ Yes ☐ No
	• If yes, type?	
	• Onset?	
59.	**Do you have a family history of diabetes or high blood sugar?**	☐ Yes ☐ No
	• If yes, who?	
60.	**Have you ever had increased blood sugars?**	☐ Yes ☐ No
	• If yes, please describe:	
61.	**Have you ever been diagnosed with thyroid disease?**	☐ Yes ☐ No
	• If yes, what and when?	
	• Treatment:	
62.	**Does your family have a history of any serious health issues?** (i.e. heart disease, stroke, kidney disease, liver disease, lupus, any connective tissue disease)	☐ Yes ☐ No
	• If yes, please outline:	

Legal Name: _____ **Date:** _____

SOCIAL					
63.	Are you the sole wage earner in your household?				☐ Yes ☐ No
64.	Donating an organ requires time off work to recover. Are you able to take time off work? (4 to 6 weeks for kidney donation; 8 to 12 weeks for portion of liver donation)				☐ Yes ☐ No
65.	Employer:				
	Occupation:		Highest Education Level:		

- We are required to ask the following questions to meet government regulations.
- We acknowledge that these are of a sensitive nature and all information will be kept strictly confidential.
- If you have any questions, please speak with a member of the living donor team.

66.	In the past month, have you been exposed to known or suspected HIV, Hepatitis B and/or Hepatitis C infected blood through sexual contact, skin punctures, or through contact with an open wound, non-intact skin or mucous membrane?	☐ Yes ☐ No
67.	In the past month, have you been diagnosed or treated for syphilis, chlamydia or gonorrhea?	☐ Yes ☐ No
68.	In the past month, have you ever had sex in exchange for drugs?	☐ Yes ☐ No
69.	In the past month, did any of your sexual partners have sex in exchange for money?	☐ Yes ☐ No
70.	In the past month, did you have sex with any person known or suspected to have hepatitis or HIV?	☐ Yes ☐ No
71.	In the past month have you or any sexual partner used a needle to inject drugs into your veins, muscles or under the skin, for non-medical use?	☐ Yes ☐ No
72.	In the past month have you been in juvenile detention, lock up, jail or prison for more than 72 consecutive hours?	☐ Yes ☐ No
73.	In the past month, did any of your sexual partners have sex in exchange for drugs?	☐ Yes ☐ No
74.	**FOR MALES:** In the past month, have you had sex with another man?	☐ Yes ☐ No

OTHER		
75.	Do you have any metal implants in your body?	☐ Yes ☐ No
	• If yes, explain?	
76.	Is there any other information that we should know?	☐ Yes ☐ No
	• If yes, what?	
77.	Having answered all questions about medical conditions and behavioral risk factors is there any reason why you think you should not be an organ donor?	☐ Yes ☐ No
	You do not have to give an explanation for your answer.	

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Legal Name: _____ **Date:** _____

FAMILY HISTORY

Relation	NAME	PRESENT AGE (OR AGE AT DEATH)	- IF LIVING: HEALTH STATUS *(GOOD, FAIR POOR)* - IF DECEASED: CAUSE OF DEATH
Father:			
Mother:			
Sibling 1:			
Sibling 2:			
Sibling 3:			
Sibling 4:			
Sibling 5:			

FORM APPROVAL AND VERIFICATION

I have answered the questions for this Living Donor Assessment Form from Ohio State's Comprehensive Transplant Center truthfully and to the best of my ability.

_____
Legal Name of Potential Donor

_____
Signature of Potential Donor

_____
Date

If you know your blood type, please include a
COPY OF YOUR AMERICAN RED CROSS BLOOD TYPE CARD
with this form and return them to:

The Ohio State University Wexner Medical Center
Comprehensive Transplant Center | Pre-Transplant Office
300 W. 10th Ave., 11th Floor
Columbus, OH 43210
614-293-6724 or 800-293-8965
Fax: 614-293-6710

Legal Name: _____ **Date:** _____

PRE-EVALUATION CONSENT FORM

I acknowledge that various tests will need to be performed prior to scheduling a formal donor evaluation.

Such tests may include:

- Blood Typing (ABO)
- HLA / Tissue Typing
- Crossmatch (compatibility test)
- Blood Chemistries
- Glucose Tolerance Testing
- Urinalysis and 24-Hour Urine Chemistries
- Ambulatory Blood Pressure Monitoring
- Diagnostic Imaging by ultrasound or X-ray

I hereby voluntarily consent to having all such tests performed.

Legal Name of Potential Donor: _____

Potential Donor Signature: _____

Date: _____

Patient Name (First, Middle, Last)	Date of Birth: ___/___/_____	Last 4 digits of Patient's Social Security Number:	Telephone Number: ( )

Patient's Address

Dates of Service to Release (From): _____ (To): _____

Specific Reports to be Disclosed:

❑ Emergency Department Records	❑ Progress Notes	❑ Laboratory Reports
❑ Discharge Information	❑ Therapy Notes	❑ Pathology Reports
❑ History and Physical Exam	❑ Plan of Care	❑ Radiology Reports
❑ Consults/Assessment	❑ Operative/ Procedure Reports	❑ Other: _____

Purpose of Disclosure: ❑ Medical Treatment ❑ Disability ❑ Insurance ❑ Legal Reasons ❑ Personal ❑ Other:

Release Information From:

❑ James Cancer Hospital and Solove Research Institute

Ohio State University Wexner Medical Center
❑ Brain and Spine Hospital
❑ Dodd Hall
❑ East Hospital
❑ OSU Harding
❑ Other (Specify) _____
❑ Ross Heart Hospital
❑ University Hospital

Release Information To: ❑ Other (specify recipient and complete address below)

_____
(Name)
_____
(Address)
_____
_____
(Phone) (Fax)
_____
(Patient's email)

Release Information To: ❑ The Ohio State University Wexner Medical Center (specify provider) ❑ James Cancer Hospital and Solove Research Institute (specify provider)

_____
_____
_____
_____

Based on regulatory requirements, a fee may be charged for copies of medical records. If you have questions about an invoice you have received, please contact CIOX Health at 1-800-367-1500. CIOX Health is a business associate of The Ohio State University Wexner Medical Center and James Cancer Hospital and Solove Research Institute.

I give the facility as indicated above and its employees and business associates, CIOX, permission to release my medical record, or parts of my record, as noted above and as defined in the designated record set. I understand that the information released may include treatment for physical and mental illness, alcohol or drug use, AIDS (Acquired Immunodeficiency Syndrome) or HIV testing. I know I need to sign a separate form to release any notes related to psychotherapy. This form is valid for one year unless I give written notice prior to the release of the information, as stated in the Notice of Privacy Practices.

The information released as a result of this form may be re-disclosed by the recipient and may no longer be protected by federal or state privacy rules, such as HIPAA.

I understand that treatment or payment for the care I have received at OSUWMC is not dependent on my signing this release, unless treatment is for research or the care was given to provide information to a third party.

If I am requesting records related to substance use disorder, federal law prohibits further release of my information without my written consent and requires an additional specific form to be completed before the records are provided.

_____ _____
Signature of the Patient or Person Authorized to Consent — Date Signed

_____
Relationship if not the Patient

_____ _____
Witness (optional) — Date Signed

Submit requests to one of the following:

The Ohio State University Wexner Medical Center
Medical Information Management
110 Doan Hall, 410 West 10th Avenue
Columbus, Ohio 43210-1228
Phone: (614) 293-8657

East Hospital
Medical Information Management W113
181 Taylor Avenue
Columbus, Ohio 43203 - 1779
Phone: (614) 257-2544

The James Cancer Hospital and Solove Research Institute
1st Floor James Cancer Hospital
James A061
460 West 10th Ave
Columbus, OH 43210 - 2500
Phone: (614) 293-8657

MS0001

❑ **THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER**

❑ **JAMES CANCER HOSPITAL AND SOLOVE RESEARCH INSTITUTE**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MC040184 (11/19)

Patient Name:

Medical Record Number:

Date of Birth: