Dear Kidney Donor:

Welcome to The Christ Hospital Health Network Kidney Transplant department. There are two Kidney Transplant Donor Coordinators, Tricia Monson and Bre Bronson Both are registered nurses. As Kidney Transplant Donor Coordinators for The Christ Hospital Health Network, we are here to assist you in the donation process. We will schedule tests, provide education and answer questions that you may have to make the best decision regarding donation. We are your ADVOCATE.

Thank you for your interest in kidney donation. In this packet you will find the following: the registration form, donor questionnaire, release of protected health information form, social work questionnaire, TB Screening Questionnaire, donor informed consent, and information on living donation. We hope the donation information provided is helpful. Please share this information with your loved ones.

If you decide you want to move forward, please complete and return the registration forms. Once the forms have been reviewed, we will contact you. If you are a candidate, we will register you into our system and provide you with instructions for tissue typing. It is important that the tissue typing is coordinated with the timing of your recipient's tissue typing. Our staff in the transplant clinic will orchestrate the timing of the appointments. You must have tissue typing completed within a 24-to-48-hour period of the recipient. You will need to call Gail Krisko at 513-585-0803 to make your appointment. **Remember, you must be registered before you can make an appointment for tissue typing.**

Tissue typing or 'matching· is determined by blood tests that look at protein markers and blood type. Your blood is matched against the recipient's blood for a reaction. This test takes three weeks to get the results. The results are then reviewed by the transplant team to determine the best match for the recipient. You will be contacted with the results.

If you are selected as the prospective donor, we will ask you to complete the transplant work-up (evaluation) at The Christ Hospital Health Network. A 'routine' work-up includes meetings with a donor coordinator, social worker & nurse practitioner. It also includes blood work, urine tests, EKG, & chest x-ray. Depending on age, women will need a yearly mammogram, clinical breast exam, and Pap smear. Depending on age, men will need prostate exams. Men and women over 50 need a colonoscopy. A CT-Angiogram of the abdomen is also ordered. We use this imaging specifically to examine the anatomy of the kidneys. A surgeon will determine which kidney is selected for donation based on the results of this imaging.

When your work-up (evaluation) is complete, The Christ Hospital Health Network Transplant Team will review your health record. You will be notified of your donation candidacy. The options include: approval, disqualification, or additional testing. When both the recipient and donor have received final approval, a transplant date can be scheduled.

It Is important that you know that you can choose to discontinue the donation process at any time and your decision will remain confidential. Please do not hesitate to contact your coordinator with any questions.

We look forward to working with you and wish you the best.

Best regards,

Tricia Monson, RN *Bre Bronson, RN*

Tricia Monson, BSN, RN Breanna Bronson, RN

The Christ Hospital Health Network

DONOR REGISTRATION INFORMATION

Phone: 513-585-2493   Fax: 513-585-0433

(Please be advised donor information is needed ONLY to register donor in the Christ Hospital system. The recipient will be the guarantor and the recipient's insurance will be billed for all donor services. Without this information we cannot order any donor tests.)

Date: __________ Name: ____________________________________ Preferred name __________
(Full legal name with middle initial)

DOB: ______________ Age________ Sex: Male____ Female_____ SS#:_________________

Marital status: __________ Race___________ Hispanic? Yes / No Preferred language: _______

Religious Preference: ____________ Height ________Weight _______ Blood Pressure _________

Primary Care Physician Name/ Phone #: ____

Donor Address: ______________________________City/ST: _______________Zip:___________

County: ______________________ Email: _________________________________

Home Ph#:___________________ Cell Ph#:_______________

Best way to contact you during the day? (Circle one) Home Ph # / Cell Ph # / E-Mail

Emergency Contact: ______________________________ Relationship: _________________

Home Ph #:_______________________________Cell Ph #:____________________

Emergency Contact Address: ____

Donor Place of Employment: ____________________________Job Title: ________________

Employer Address: ____________________________________ Work phone: _____________

Donor Insurance Name: ________________________ Subscriber Name: _________________

Insurance Address & Ph #:____

ID#: ________________________ Group Name & #:_________________________________

Name of Recipient: ________________________ Recipient's DOB (if known) _______
Relationship to Recipient: ____
(Example: mother, father, sister, brother, friend, etc.)

For Internal Use Only
Recipient ______________________________ Ordering Nephrologist_________________________
Recipient MR# ________________ SW_________ Recipient ESRD_________________________
Recipient DOB________________
Donor Medical Record #______________________

INFORMATION GIVEN IN THIS QUESTIONNAIRE WILL REMAIN CONFIDENTIAL AND AVAILABLE TO THE CHRIST HOSPITAL TRANSPLANT TEAM ONLY

The United Network for Organ Sharing (UNOS) instituted policy changes for all living organ donation. The Organ Procurement and Transplantation Network (OPTN) Policy 14.0 requires that transplant centers assess all potential living donors for risk factors for acute transmission of HIV, Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) infection. Questions to identify individuals with risk factors were defined by the 2020 Public Health Services (PHS) Guideline, www.publichealthreports.org. The purpose of this policy is to reduce the risk of transmissible disease in living donation and transplant. We understand that these questions are very personal in nature and therefore wanted you to be aware, prior to your interviews, that this information will be addressed during your medical evaluation, your meeting with the social worker, and pre admission testing if you proceed with donation. Responses will be kept strictly confidential and only available to our Transplant Team.

Please note: The definition of "had sex" in the questions below refers to any method of sexual contact, including vaginal, anal, and oral contact. Risk criteria is for the 30 days before organ procurement.

Donor Risk Factors	Not Applicable	YES	NO
Have you had sex with a person known or suspected of having HIV, HBV, or HCV infection in the preceding 30 days?			
For Male Donors: Have you had sex with another man in the preceding 30 days?			
Have you engaged in sex in exchange for money or drugs in the preceding 30 days?			
Have you had sex with a person who had sex in exchange for money or drugs in the preceding 30 days?			
Have you injected drugs by intravenous, intramuscular, or subcutaneous route for nonmedical reasons in the preceding 30 days?			
Have you had sex with a person who injected drugs by intravenous, intramuscular or subcutaneous route for nonmedical reasons in the preceding 30 days?			
Have you been incarcerated (confinement in jail, prison, or a juvenile correction facility) for equal to or greater than 72 consecutive hours in the preceding 30 days?			
A child who has been breastfed by a mother who is known to be infected with HIV infection.	X		
A child born to a mother with HIV, HBV, or HCV infection	X		
Unknown medical or social history			

Signature: ____ **Date:** _______________

Please Check **Yes** or **No** to the following questions:

Have you ever been treated for the following?	YES	NO	Have you ever been treated for the following?	YES	NO
Abdominal Pain			Hormone Supplements		
Alcohol abuse			Impaired Hearing		
Anemia			Impaired Vision		
Anxiety			Irregular Heartbeat		
Arthritis			Kidney Biopsy		
Backache			Kidney Infection		
Bladder Infection			Kidney Injury		
Bladder Problem			Kidney Stones		
Bleeding Problems			Leg Cramps		
Blood Disorders			Leg Pain		
Blood in Urine			Liver Disease		
Blood Transfusions			Long Term Skin Disease		
Blood Clot			Lung Disease		
Bruising			Lupus		
Cancer			Marijuana Use – Amt per day / Date last used		
Cataracts			Menstrual History		
Change in Bowel Habits			Miscarriage		
Chest Pain			Night Time Urination		
Chronic Pain			Nose Bleeds		
Concussion			Numbness		
Congestive Heart Failure			Pacemaker		
Constipation			Polycystic Kidney Disease		
Convulsions			Pregnancy		
Depression/Worry			Prostate Difficulties		
Diabetes			Prostate Enlargement		
Diabetes while Pregnant (Gestational)			Protein in urine		
Diarrhea			Rectal Bleeding		
Difficult Urination			Rheumatic Fever		
Dizziness/Vertigo			Sickle Cell Anemia		
Drug Addiction			Smoke Cigarettes – How Many per day?		
Ear Drainage			Street (Illicit) Drug Use – Name / Date last used		
Ear Ringing			Stroke		
Eating Disorders			Swelling		
Fainting Spells			Thyroid Imbalance		
Frequent Urination			Tuberculosis		
Glaucoma			Ulcers/Heartburn		
Gout			Urinary Tract Infection		
Headaches			Venereal Infection		
Heart Attack			Vomited Blood		
Heart Disease			Weight Change within last 6 months		
Heart Murmur			Were you born premature		
Hemorrhoids			What was your birth weight if known _________		
Hepatitis					
Herpes					
Hiatal Hernia					
High Blood Pressure (Hypertension)					
Hormone Imbalance					

If you have answered "Yes" to any of the previous questions, please use this space to provide us with as much detail as possible, including dates and any other pertinent data.

1.____

2.____

3.____

4. ____

Please check Yes or No to the following Questions. Also, if you check Yes to any of the questions please give us as much detail as possible, including what family members and any pertinent information.

	Yes	No	Comments-Please use this field to provide any pertinent information
Do you have a family history of Heart Disease? If Yes please explain.			
Do you have a family history of Cancer? If so what type?			
Do you have a family history of Kidney Cancer? If yes, please explain.			
Do you have a family history of Kidney Disease? What Type if known. Any family history of kidney stones or cysts?			
Do you have a family history of Diabetes? If yes, please indicate Type I or Type II if known.			
Do you have a family history of high blood pressure (hypertension)?			

Please list prior surgeries / hospitalizations:

Date Reason Hospital (City, State) Doctor

1.____

2.____

3.____

Any additional questions or comments?

1.____

2.____

3.____

List all medications you are currently taking including all over-the- counter medicines /Birth Control pills/Hormone Replacement Therapy /herbals/supplements:

1.____ 3. ____

2. ____ 4.____

Do you have prescription coverage? Yes No

Do you have any known allergies? Please list and what type of allergic reaction did you experience?

____

____

Will it be difficult for you to take time off of work to donate and recuperate? Yes______ No______

If yes, please explain____

What is your blood type? (If known) ________________________________

In the event that you are ABO incompatible (you don't share the same blood type or compatible blood type) **with the intended recipient; would you consider donating through our participating Kidney Exchange Program (KEP), the National Kidney Registry (NKR)?**

______ Yes ______ No ______ Maybe

***** Please refer to the right side of your green folder for more information concerning the NKR.**

Why do you wish to donate? ____

____

____

Thank you for your interest in Kidney Donation! We appreciate you taking your time in completing this packet with such accuracy and so much detail. We use this information in determination of your eligibility for potential kidney donation. When I receive these forms, I will contact you regarding the next steps in the donation process.

THE CHRIST HOSPITAL
TRANSPLANT SOCIAL WORK
Pre-Transplant Social History
Donor Assessment

(Please answer all questions. Each question is important, but no single question will rule you out as a donor. It is best to answer all questions honestly and completely as possible.)

Name: ____ DOB: ___________________________________
Address: ____ Email: __________________________________
City: ____ Home phone: (____) ______-______________
Zip: ____ Cell phone: (____) ______-________________
Your Relationship to Recipient___________________________ Your citizenship __________________________

FAMILY/SOCIAL INFORMATION (Use back of page as needed)

Immediate Family
Marital Status: ___ Single ___ Married (If married, for how long? ______) ___ Separated ___ Divorced
Home status: ___ Own ___Rent ____ Household of another
Who lives in your home?

Name	Age	Relationship to you

Extended Family

Name	Age	Relationship to you

What are the most common family conflicts within your immediate and/or extended family? _________________
____
____

Early Life:
Where were you born and raised? ____
What was life like for you growing up? (Parents married? Divorced? Conflicts?)
____
____
____
How would you describe your "role" within your family growing-up? Circle one.
"The Responsible One", "The Black Sheep", "The Peacemaker", "The People-Pleaser", "The Invisible One", "The Joker", Other___________________ .

Did you experience significant loss as a child? (Death of parent? Grandparent? Close friend? Loss of friends due to changing schools?) ____
____

Did you experience any traumatic incidents during childhood such verbal, physical or sexual abuse? ______________
If yes, what happened? ____
____
What was school like for you most of time? ____
____
____
Were you in sports or other activities? ____
____
What was your favorite year of school? ____________ Why? ____
____

Living Donation
Does the recipient know that you hope to donate? ______ If so, what was has his/her response _________________
____
How often do you have contact with the recipient? ____
What is the cause of the recipient's kidney failure? ____
____
Describe the changes in the recipient's life that you expect to see during the first year after transplant. ____________
____
What other treatment options are available to the recipient? ____
____
Have you ever donated blood or done volunteer work? ____
____
What are your main reasons for wanting to donate?
1) ____
2) ____

What circumstances might cause you to change your mind about donating? ___________________________________
____

Potential donors are often disqualified in the early stages of their workup. Have you considered this possibility? How do you imagine you will feel? ____

If you are able to donate, how will your life change as the result the recipient receiving your kidney? ______________
____

If you were to decide not to donate how do you imagine your relationship with the recipient might change? ________
____

Do you feel confident in your decision to be worked-up as a potential donor? ____________________________________
Most donors have some reservations about donating during the early stages of their workup. Do you have any? _____
If so what are they? ____
____

Do you have concerns about the medical and surgical risks involved in donating? _________________________________
____

How does your spouse or significant other (or parent) feel about your wish to donate? ___________________________
____

To what extent do they understand the potential risks to your health as a result of your donating? _______________
____
Do you have a Living Will? _______
If you have religious beliefs, regardless of denomination or religion, how have these beliefs effected your decision to donate? Also, have your beliefs affected how you think the transplant and your recovery will go? _______________
____.
Please list your biggest worries about donating?
1.____
2.____
3.____

Post-Surgical Recovery Plan
Where will you stay once discharged from the hospital? ____
Who will drive you there? ____
Who will be your primary caregiver once you are discharged from the hospital? ________________________________
Who will be your secondary caregiver? ____
If you have young children, who will look after them, get them to school, etc.? _________________________________
Donors are typically off from work for 4-6 weeks. Will being off from work for several weeks create financial hardship for you? __________________ Do you have FMLA? ______ Short term Disability? _____ If so, at what % _______
Who could you turn to for a loan if you needed financial help while you were off from work? ____________________
You will not be able to lift anything weighing more than 10lbs for 6-8 weeks. Will this present a problem for you at work? _____ At home? ____ (Remember young children, pets, and household items can easily weigh more than 10lbs.)

Activities
Are you active in any clubs, religious or social organizations? ____ If yes, please list:
1.______________________________________ 2.____
2.______________________________________ 3.____
What are your favorite things to do to relax and enjoy yourself?
1.______________________________________ 2.____
3.______________________________________ 4.____

Education/Employment
What was the last grade of school you completed? ____
Where did you go to school? High School_________________________ College/Grad School______________________
Are you currently employed? _____Yes _____No
If yes, what is the name of your employer? ____
Please describe in detail what you do at work. ____
____
How long have you worked there? ____
Have you discussed donating with employer? _____ Yes ____No
If yes, describe employer’s response: ____
Do you have medical insurance? If so, what is it?____
Are you eligible for short-term disability? _____ Yes _____ No FMLA _____Yes _____No
Is your Spouse/S.O. employed? _____Yes _____ No
If yes, where? ____

Medical Information

Name of your Primary Care Physician/Phone:_________________________ (_____)___________________________

Please list all past surgeries: 1.____________________________ 2.____

3.____________________________ 4.____

Do you exercise regularly? If so, describe what you do and how often.

____

_ ____

How well would you say that you cope with stress? Pretty well ____ So So ____ Not good at all _____

Describe a time in your life that was very stressful. What was going on? ______________________________________

____

What did you do to help yourself cope with the stress? ____

____

Lifestyle

Do you think you live a healthy lifestyle ____________? How much water do you usually drink a day? ___________

What medication(s) do you usually take for minor aches and pain? ________________

Do you smoke? Yes___ No ___ If yes, how much? _______ How long have you smoked? ________ If you smoked previously, when did you quit? _________________

Do you drink alcohol? Yes___ No___ If yes, what is your drink of choice? ______________________________

How many drinks per week on average? _____ Have you ever been treated for alcohol abuse? ____Yes ____No

Do you smoke marijuana? ____ If yes, how many times a day/week? _____

If you smoke marijuana regularly, would you be able to stop prior to donation ____________________?

Have you ever taken prescription medicines? ___Yes ___No

On average, how many hours of sleep do you get per night? _________

Have you had any appetite changes within the past month? ____

Have you ever been diagnosed with an eating disorder? ____ Yes ____ No If yes, please describe; include when and for how long you were bulimic, anorexic and whether or not you purged. _______________________________________

____

Are you currently being treated with medication for depression or anxiety? ____Yes ____ No If so, why are they being prescribed? ____ Do they help? ______________________________

Have you been diagnosed with a psychiatric illness? ____Yes ____ No If yes, what is your current treatment? _____ ____ Have you seen a counselor, a psychiatrist, or a psychotherapist? ____ Yes ____ No If yes, when and for how long were you in treatment? ___________________

____

Please briefly describe the circumstances and whether you found it helpful. ______________________________________

____

Thank you for completing this form. Please sign and date.

Signature: ____ **Date**________________________________

Kidney Transplant Center
TB Screening Questionnaire

Donor Name (Print): _________________________________ DOB:______________

1. **Do you have a history of a positive TB Skin Test or history of having TB? Yes No**

2. **Do you now have any condition requiring prolonged steroid or immunosuppressive therapy? Yes No**

3. **Do you have an immunosuppressive illness at the present time? Yes No**

4. **Have you had any of the following in the past year (12 months)?**
   - **Recent close contact with a person having active Tuberculosis? Yes No**
   - **Unexplained productive cough? Yes No**
   - **Coughing up blood? Yes No**
   - **Unexplained weight loss or increased fatigue? Yes No**
   - **Unexplained fever or night sweats? Yes No**

5. **Have you had the BCG vaccine? Yes No**

Signature: ____Date: _____________

The Christ Hospital Health Network

TRANSPLANT NUTRITION ASSESSMENT FORM - Donor

Name: ___________________________________ Date of Birth: _______________________

(Each patient who is evaluated for an organ transplant is assessed by a Registered Dietitian.)

1. Height________ Weight________ Please circle if you are a Donor or Recipient

2. Three months ago, I weighed ________ pounds. Six months ago, I weighed ________ pounds.

3. A special diet/nutrition program that you may follow (check all that apply):

___Low Fat ___Low Sodium ___Diabetic ___Renal ___High Protein
___Weight Loss ___No Gluten ___Vegetarian ___Vegan ___No Dairy
Other: ________________________

4. Food allergies/intolerances: ____

5. In the past three months, my appetite has: ___Increased ___Decreased ___Not Changed

6. Problems that affect your food intake (check all that apply):

___Food doesn't taste good ___Loss of appetite ___I get full too fast
___Chewing problems ___Swallowing problems ___Nausea
___Heartburn/reflux ___Food smells bad Other _____________

7. Which meals do you eat regularly (check all that apply):

___Breakfast ___Lunch ___Dinner/Supper ___Snacks ___Skip meals often

8. Do you take any nutritional supplements such as Ensure, Boost, Nepro, Herbal Supplements, or others?

_____No _____Yes (please list) ____

9. Daily fluid intake:

___Less than 3 cups ___3-5 cups ___6-8 cups ___More than 8 cups

Doctor orders: ____

10. I have skin wounds/sores that are healing slowly: _____No _____Yes

If yes, where? ____

11. Do you exercise? _____No _____Yes

If yes, how often __________________________ Type of exercise: _______________________

Physical limitations to exercise: ____

12. Do you have any nutritional concerns? Please describe. ________________________________

____

Patient signature: ____ Date: ______________________

Renal Transplant Dietitian signature: ________________________ Date: ______________________

Created: 1/4/17, 8/22/18, 1/14/20, 2/17/21, 3/10/22