



The UNIVERSITY of OKLAHOMA

920 N.E. 13<sup>th</sup> St. | Ste. 2000 | Oklahoma City, OK 73104

Main Clinic: (572) 244-0060 | Fax: (572) 244-9836 | Living.Donor@OUHealth.com

## Living Donor Application

Thank you for your interest in Living Kidney Donation at OU Health. We are committed to providing treatment options to our patients living with and managing end-stage renal disease. A kidney from a living donor is the best treatment option, as these kidneys function better and last longer than kidneys from a deceased donor.

### Who can be a donor?

- Ages 18 - 70
- BMI of 30 or less
- Free of:
  - Diabetes
  - Uncontrolled high blood pressure
  - Active cancer
  - Kidney disease or recent kidney stones
  - Chronic pain or infection
- Adequate social support, stable mental health and financial security
- Active health insurance
- Related or unrelated to the recipient

If you meet the criteria above and would like to be considered as a living kidney donor, please fill out the form below and someone from the transplant team will contact you. Please provide as much information as possible.

### PATIENT INFORMATION:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Male / Female DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Do you currently have health insurance?  Yes  No

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

May we leave a message?  Yes  No Email Address: \_\_\_\_\_

**PHYSICIAN INFORMATION:**

Primary Care Physician: \_\_\_\_\_ Last Visit: \_\_\_\_\_

**Additional Care Providers**

List all other doctors you see, reason for seeing them, and their phone number.

If none, put N/A.

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**EMPLOYMENT HISTORY:**

Are you currently employed?  Yes  No

Who is your employer? (If none, put "None".) \_\_\_\_\_

What is your job title? (If none, put "None".) \_\_\_\_\_

How long have you worked there? (If none, put "None") \_\_\_\_\_

**MEDICAL HISTORY:** (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Blood Clots                           | <input type="checkbox"/> Kidney Disease                           |
| <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Polycystic Kidney Disease (PCKD)         |
| <input type="checkbox"/> Cirrhosis of Liver                    | <input type="checkbox"/> Kidney Stones                            |
| <input type="checkbox"/> Cold Sores or Herpes                  | <input type="checkbox"/> Memory Problem                           |
| <input type="checkbox"/> Crohn's Disease or Ulcerative Colitis | <input type="checkbox"/> Osteoporosis                             |
| <input type="checkbox"/> Depression                            | <input type="checkbox"/> Pneumonia                                |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Prostate Issues                          |
| <input type="checkbox"/> Emphysema / COPD                      | <input type="checkbox"/> Schizophrenia                            |
| <input type="checkbox"/> Foot Ulcers                           | <input type="checkbox"/> Sinus Infections                         |
| <input type="checkbox"/> Gallbladder Disease                   | <input type="checkbox"/> Skin Cancer                              |
| <input type="checkbox"/> Heart Attack or Heart Failure         | <input type="checkbox"/> Stroke                                   |
| <input type="checkbox"/> Hepatitis A                           | <input type="checkbox"/> Thyroid Issues                           |
| <input type="checkbox"/> Hepatitis B                           | <input type="checkbox"/> Tuberculosis / Positive Skin Test for TB |
| <input type="checkbox"/> Hepatitis C                           | <input type="checkbox"/> Ulcers                                   |
| <input type="checkbox"/> High Blood Pressure (Hypertension)    | <input type="checkbox"/> Urinary Tract Infections (UTIs)          |
| <input type="checkbox"/> High Cholesterol                      | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Jaundice                              |   |

If you selected blood clots, cancer, kidney disease/stones, or other, please describe in further detail and indicate when it occurred.

Have you ever been pregnant? If yes, were you diagnosed with gestational diabetes, pregnancy induced hypertension, and/or pre-eclampsia?

**Surgical History**

List any surgeries you've had. If none, put "None".

**MEDICATIONS:**

(Can add additional medications and attach, if needed.)

| Medication Name | Medication Dose | Medication Frequency |
|-----------------|-----------------|----------------------|
|                 |                 |                      |
|                 |                 |                      |
|                 |                 |                      |
|                 |                 |                      |
|                 |                 |                      |

**FAMILY MEDICAL HISTORY:** (check all that apply)

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Attack or Heart Failure |
| <input type="checkbox"/> Anxiety    | <input type="checkbox"/> High Blood Pressure           |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Thyroid Disease               |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Transplant                    |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> None                          |

If you selected cancer, diabetes, kidney disease or transplant, please indicate family member, which type and when.

Do you have children?  Yes  No  
If yes, how old are they?

**ALCOHOL HISTORY:** (Please answer honestly. All answers are confidential.)

Do you currently use alcohol?  Yes  No  
If yes, how much / how often? \_\_\_\_\_

**SUBSTANCE ABUSE CHECKLIST:** (Please answer honestly. All answers are confidential.)

Please check any of the substances below you have used, even if it was only once.

- |  |  |
|--|--|
| <input type="checkbox"/> Cocaine                   | <input type="checkbox"/> Prescription Opiates (Oxycontin, Vicodin, Percocet, etc.) |
| <input type="checkbox"/> Crystal Meth              | <input type="checkbox"/> Injected any kind of substance into your skin or veins    |
| <input type="checkbox"/> Ecstasy / Mushrooms / LSD | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Heroin                    | <input type="checkbox"/> None  |
| <input type="checkbox"/> Marijuana                 |  |

**RECIPIENT INFORMATION:** (Is there someone you wish to donate to?)

Recipient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Donor Relationship to Recipient: \_\_\_\_\_

**ACKNOWLEDGEMENT:**

I attest that the information provided to the Division of Organ Transplantation is true to the best of my knowledge. I have been informed about the program's purpose for use of this information and have been given The opportunity to ask questions. I understand that OU Health Medical Center, Division of Organ Transplantation is required by law to maintain the privacy/confidentiality of my health information. By typing your name below, you attest to the statement above and that your typed name will constitute your signature on this form.

**Your Digital Signature (full name):**

**Signature Date:**