OU Health
Transplant Institute

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Main Clinic: (405) 271-7498 | Fax: (405) 271-4329 | 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: _____

Male / Female Height: _____ Weight: _____

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.

_____

_____

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)

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

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)

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Attack or Heart Failure
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transplant
- ☐ Other
- ☐ 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.

- ☐ Cocaine
- ☐ Crystal Meth
- ☐ Ecstasy / Mushrooms / LSD
- ☐ Heroin
- ☐ Marijuana
- ☐ Prescription Opiates (Oxycontin, Vicodin, Percocet, etc.)
- ☐ Injected any kind of substance into your skin or veins
- ☐ Other
- ☐ None

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: