Date Received by Transplant Office: DD/MM/YYYY **MR#:**

KIDNEY DONOR EVALUATION FORM

Department of Transplant Surgery, 9200 West Wisconsin Avenue, Milwaukee, WI 53226
Tel: 414-805-0310 Fax: 414-805-1080

Thank you for your interest in kidney donation. To start the live kidney donor evaluation process, please complete this questionnaire, answering all questions truthfully and accurately and mail or fax it to the above. All the information you share with transplant team is strictly confidential. In order to qualify as a living donor, you must:

1) Be willing to donate without any pressure from a family member, friend or someone you know.
2) Be healthy and free from any major physical or mental illness.
3) Usually between the age of 18 and 65 and if a woman, not be pregnant.

Name			Social Security #	Gender: M F
Maiden Name			Date of Birth	Age:
Street Address			Race	Religion
City	State	Zip	Home Phone ( ) ☐ Call first	
Employer			Work Phone ( ) ☐ Call first	
Occupation	Retired/Disabled?		Cell Phone ( ) ☐ Call first	
# years of school completed/Highest Degree Obtained:			Primary Medical Doctor: Address/Tel/Fax:	
Name of person to receive kidney:				
Relationship to recipient of kidney:			Blood Group:	
Length of this relationship:			Blood Pressure Reading: Date: *(have checked by a trained person)*	
Health Insurance:			Height:	Weight (lbs):
			Life Insurance:	

SYMPTOMS REVIEW: DO YOU HAVE OR HAVE YOU EVER HAD:

☐ Fatigue ☐ Fever/Chills > 10 days ☐ Night Sweats ☐ Exertional Intolerance ☐ Skin rash ☐ Lymph node swelling
☐ Depression ☐ Anxiety ☐ Suicidal ideation ☐ Irritability ☐ Psychiatric care or counseling

☐ Visual Problems ☐ Ear Problems ☐ Sinus problems ☐ Shortness of Breath ☐ Persistent cough ☐ Dizziness
☐ Positive TB Skin Test ☐ Coughing up blood ☐ Passing out spells ☐ Headache ☐ Numbness ☐ Weakness

☐ High Blood Pressure ☐ Chest Pain ☐ Heart Attack ☐ Irregular heart beat ☐ Palpitations ☐ Abnormal Heart tracing
☐ Abnormal Heart Sounds ☐ Rheumatic Fever ☐ Leg Swelling

☐ Persistent Nausea/Vomiting ☐ Persistent Diarrhea/Constipation ☐ Stomach Pain ☐ Unexplained Weight Loss
☐ Blood in Stool or Vomit ☐ Jaundice ☐ Hepatitis

☐ Blood in urine ☐ Protein in urine ☐ Kidney Stones ☐ Recurrent Urine/Bladder Infection ☐ Kidney Problems
☐ Easy Bruising ☐ Anemia ☐ Sickle Cell Anemia ☐ Arthritis / Joint Pains ☐ Muscle aches ☐ Back ache

☐ Acupuncture ☐ Tattoo ☐ Body piercing ☐ Sexually Transmitted Disease ☐ Blood Donation ☐ Received Blood Transfusion ☐ Refused for Blood Donation

☐ If yes to any symptoms, please explain _____

If applicable please list the dates of the most recent testing for the following:

☐ PAP_____ ☐ Mammogram_____ ☐ Colonoscopy_____ ☐ Prostate Screening_____
☐ Stress Test _____ ☐ Physical Exam_____

If you are a woman please answer the following questions below:

1. Do you have irregular/heavy periods: ☐ Yes ☐ No ☐ Not Applicable Explain _____
2. Any problems during prior pregnancies (diabetes, high blood pressure, leg swelling, miscarriage, abortion, etc)

   _____
3. Are you planning future pregnancies ☐ Yes ☐ No ☐ Not Sure Explain _____

SOCIAL HISTORY:

1. Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
2. Number of Children & their ages_____ 3. Name of spouse/significant other_____
4. Does he/she accept your plan to donate ☐ Yes ☐ No

   If not, why? _____
5. Smoking History (How much – for how long) _____
6. Alcohol Use History (How much – how often) _____
7. Recreational Drug Use History (Which drug/how often/last use?)_____

FAMILY HISTORY- Please list the medical problems in the following family members

1. Father_____ 2. Mother_____
3. Brothers_____ 4. Sisters_____
5. Grandparents_____ 6. Children _____

PERSONAL MEDICAL AND SURGICAL HISTORY: Do you have or have you ever had:

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Lung Disease ☐ Heart Disease ☐ Liver Disease
☐ Psychiatric Illness ☐ Depression ☐ Stroke ☐ Asthma ☐ Seizure/Fits ☐ Tuberculosis ☐ Auto-immune Disease
☐ Other serious medical problem_____
☐ List the Surgeries that you have had _____
If yes, please provide details:

_____

_____

List All Medications you are currently taking (Ibuprofen, Naproxen, Tylenol, Protein & Creatine supplements, Herbal supplements, etc):

_____

_____

List All Medicine/Food Allergies:

_____

List anything else about your health that we should know:

_____

_____

Why do you want to donate and who brought up the idea of donation?

_____

How will you cope if the kidney you donate fails?

_____

Do your spiritual/religious/cultural belief support donation?

_____

Do you feel any pressure to donate?

_____

List any questions and/or concerns you have about donating a kidney:

_____

_____

***Would you like to know more information about or participate in the Paired Donor Exchange Program? ☐ Yes ☐ No ***

Date when this form is completed: _____

TRANSPLANT OFFICE USE ONLY:
This evaluation form was reviewed by Dr. _____ Tx Coordinator_____
Medical Decision_____ Signature/Date_____

Froedtert & Medical College of Wisconsin

Medical College of Wisconsin
10000 Innovation Drive, Ste 300
Milwaukee, WI 53226
Ph: 414-955-5489
Fax: 414-955-6606

Froedtert Hospital
9200 West Wisconsin Avenue
Milwaukee, WI 53226-3596
Ph: 414-805-2909
Fax: 414-259-1244

Community Memorial Hospital
W180 N8085 Town Hall Road
Menomonee Falls, WI 53051
Ph: 262-257-3415
Fax: 262-253-7186

St. Joseph's Hospital
3200 Pleasant Valley Road
West Bend, WI 53095
Ph: 262-836-5057
Fax: 262-836-8470

Froedtert & The Medical College of Wisconsin Community Physicians
110 Lone Oak Lane
Hartford, WI 53027
Ph: 262-836-2510
Fax: 262-670-5580

Please complete all items on the form and if you have any questions about this form, please contact the appropriate Health Information Management Department (Medical Records).

1. PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Last 4 digits of Social Security #: _____ Medical Record # (if known): _____

2. I AUTHORIZE INFORMATION TO BE RELEASED FROM:

☐ Community Memorial Hospital ☐ Froedtert Hospital
☐ Froedtert Surgery Center ☐ St. Joseph's Hospital
☐ West Bend Surgery Center ☐ Medical College of Wisconsin
☐ Froedtert & the Medical College of Wisconsin Community Physicians
■ Other: Agency/Facility/Person to release the information:
Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____ Fax #: _____

3. I AUTHORIZE INFORMATION TO BE RELEASED TO:

Froedtert & the Medical College of Wisconsin Transplant Program
Agency/Facility/Person
9200 W. Wisconsin Ave.
Address
Milwaukee, WI 53226
City/State/Zip:
Phone #: 414-805-3100 Fax #: 414-805-1080

4. PURPOSE OF DISCLOSURE

■ Further Medical Care: Relocating ☐ *Yes* ☐ *No* ☐ Insurance Eligibility/Benefits ☐ Personal Reasons ☐ Disability Determination
☐ Forms Completion ☐ Legal Investigation: Certified ☐ *Yes* ☐ *No* ☐ Other: _____

5. TYPE OF PATIENT HEALTH INFORMATION TO BE DISCLOSED

CLINIC

☐ Clinic records 2-3 year summary
For continuing care purposes, a General Abstract will be sent which includes: Progress Notes, Consults, Labs, and Radiology Reports.
■ Entire medical record for following **date(s) of service**:
From: _____ To: _____
☐ Lab Reports: Date(s): _____
☐ Radiology Report: Date(s): _____
☐ Radiology Image: Date(s): _____
■ Other: _____

HOSPITAL

☐ Hospital Summary
A General Abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ER.
■ Entire medical record for following **date(s) of service**:
From: _____ To: _____
☐ Lab Reports: Date(s): _____
☐ Radiology Report: Date(s): _____
☐ Radiology Image: Date(s): _____
■ Other: _____

6. RELEASE INFORMATION

Released via: ☐ US mail ☐ Pick up ■ Fax **Media:** ☐ Paper ☐ Electronic **My Chart:** ☐ Patient ☐ Proxy(ies) ☐ All

7. AUTHORIZATION IS EFFECTIVE UNTIL

This authorization is effective until _____ (if no date is entered the authorization will be valid for 1 year from date of signature) and includes records that were created or existed on or before the date this authorization was signed.
■ This includes records that are created **after** the date this authorization is signed, up until the expiration date. _____(initials)

8. IMPORTANT INFORMATION

The following information is important for you to read:

- I understand that the information to be disclosed may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD's, HIV test results, developmental disabilities, and genetic testing results.
- I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released.
- **I understand that I have a right to inspect and/or receive a copy of the health information to be released and I may be charged a fee for any copies of the medical records that I receive.**
- I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law.
- I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.
- A photocopy or fax of this authorization shall be considered as valid as the original.

9. SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

_____ _____ _____
Signature of Patient or Legal Representative ***Date*** ***Time***

If signed by someone other than the patient, state legal authority:
☐ Legal guardian of the patient (proof of guardianship required).
☐ Parent of the above named minor child and I represent that I have not been denied periods of physical placement with my child by a Court.
☐ The legal representative of a deceased patient (proof required).
☐ The agent under an activated Healthcare Power of Attorney (proof and statement of incapacity required).

Internal Use: Information released by

Name: _____ Phone #: _____ Records sent from Fax # _____

Authorization for Disclosure of Protected Health Information - Form # 37976

37976 Auth for Disclosure of PHI

ORIGINAL - Medical Records
CANARY - Patient

82300 05/14