Carolinas HealthCare System

Potential Living Donor Referral Form

Demographic Information (Please print) **(Use Blue or Black Ink)**

Name: ____ Date of Birth: ___________ Age: ______

Address: ____

City:______________________________ State: ____________ Zip Code: ________________

Home Phone: _____________________ Cell Phone: ___________________

Best time to contact: Morning (8am-12pm) Afternoon: (12pm-4pm) **(circle one)**

Email Address: ____

Occupation: _______________________________ Work Phone: ______________________

May we contact you at work: **YES** **NO**

US Citizen: **Yes/ No (circle one)**

Social Security Number: _____________________ (for registration purposes only)

Marital Status: _______________

Height:___________ Weight: ___________ Race: __________________ Sex: _______

Do you have children: **Yes/No** (circle one) If so, how many and ages: __________________________

Emergency Contact: ____________________Relationship: ____________Phone: __________________

Recipient Information

Recipient Name:__________________________________Recipient Date of Birth: ________________

Relationship to Recipient: Family (please specify) ________________ Friend Neighbor Coworker Other/None

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Medical History

Primary Care Physician Name and Address: ____

Primary Care Physician Phone Number: ____

Do you currently have health insurance? **Yes/ No (circle one)**
Medication and Food Allergies: ____
Are you allergic to Latex? **Yes/ No (circle one)** Are you allergic to IV contrast or Shellfish? **Yes/ No (circle one)**

MEDICAL HISTORY

Medical (SELF)	Yes	No	Medical (FAMILY)	Yes	No	Relationship
High Blood Pressure			**High Blood Pressure**			
Diabetes			**Diabetes**			
Heart Disease			**Heart Disease**			
Cancer:_________________type When: ___________			**Cancer: (type) _____________________**			
Lung Issues			**Lung Issues**			
Tuberculosis/Positive TB skin			**Tuberculosis/Positive TB skin**			
Anemia			**Anemia**			
Kidney Stone: year ____________			**Kidney Stone: year**			
Migraines/Chronic Headaches			**Migraines/Chronic**			
Seizures			**Seizures**			
Bladder Infection			**Bladder Infection**			
Gynecological Issues			**Gynecological Issues**			
Lupus			**Lupus**			
Dizziness/Memory Loss			**Dizziness/Memory Loss**			
Stomach/Intestine Issues			**Stomach/Intestine**			
Herpes			**Herpes**			
Prostate Issues			**Prostate Issues**			

Psychosocial	Yes	No
Body Piercings/Tattoos		
Do you smoke? If so, how many pack per day. ______		
Alcohol Use: **_________ amount per day** **_________ amount per week** **_________ amount per month**		
History of Drug Use		
History of Depression		
History of Bulimia/Anorexia		

Office Notes:

Please list your medications and their dosages: (Use additional paper, if necessary)

Medication	Dosage	How often?

Please list all your surgeries and dates they occurred: (Use additional paper, if necessary)

Surgery	Date	Location

Have you traveled outside of the country in the past 6 months? If yes, where? ________________________________

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Please have blood pressure check and record here____________/____________
Date:_________________Taken where: __________________________________
If your reading is greater than 140/80, please provide an additional reading__________/___________

What is your desired timeframe for donation? (Circle one) 3-6mos 6mos-1year greater than 1year

How did you hear about being a living donor? (Circle one)

Family Friends Community Social media, please specify __________Other, please specify _________________

I have read and understand the patient educational material presented to me for potential living donors. I have answered these questions to the best of my ability and without coercion. I understand that I can change my mind at any time about being a living donor.

At this time, my willingness to donate on a scale from 1-10 is_____________.

Signature: ____ Date: _______________________________

For Office Use Only
Date Received: __________________ **Assigned to: ________________________**
Reviewed by: ___________________ **BMI________________/ MRN _______________**

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