Please mail or fax this form to:
Physician's Office Building III, Suite 404
550 S. Beretania St. Honolulu, HI 96813
Phone: 808-691-1179 Fax: 808-691-8896

LIVING DONOR INTAKE FORM

Name: ________________________________ DOB: ________________________ Gender: Male or Female

Marital Status: ___ ______________________ Maiden Name: ________________ Race: _________________

Primary language: _____________________ Language preference: _____________________________________

Place if Birth: __________________________Country of Citizenship: ____________ Religion: ________________

Have you ever had prolonged residence, work or travel greater than 3 months outside of your home country or state? If so, where? ____

Have you or their significant other travel in the past 6 months? If so, where?: _________________________________

Have you ever lived in a rural area? If so, where? ____

Insurance: _______________________ Insurance Subscriber: _____________ Subscriber's DOB: _______

Phone: Home __________________ Cell ____________________________ Work: __________________

Address: ____

E-Mail: ____

Employer: __________________________ Job Title: ________________________ Status: Full Time or Part Time

Emergency Contact: ______________________ Phone: __________________________
Relationship: ____________

Name person you are donating your kidney to: ________________________________ _ Relationship: ____________

How did you hear about living kidney donation? ____

DONOR MEDICAL HISTORY: Blood Type (If known): _____________ Height: ___________Weight: ___________

Allergies: _______________________________
Medications:____

Primary Care Physician: ____________________Other physicians: ___________________________________

History of Medical Problems: Circle Y = yes, N = No. If yes, describe in notes section:

Cardiac (heart)	Y N	Diabetes	Y N	Bleeding	Y N	Drugs	Y N
Asthma/Lung	Y N	Hypertension	Y N	Psychiatric	Y N	**Family History:**	

Gastrointestinal	Y N	Kidney Infection	Y N	Tuberculosis	Y N	Diabetes	Y N
Skin	Y N	Kidney Stones	Y N	+ TB test result	Y N	Hypertension	Y N
Cancer	Y N	Infection	Y N	Tobacco	Y N	Kidney Problems	Y N
Gout	Y N	Blood Clots	Y N	Alcohol	Y N		

Notes: ____

Hospitalizations/Surgeries/Other Health Problems: ____

Females only – Hysterectomy/Sterilization/Tubal ligation: Y N Menopause: Y N

Dates of Last: Menstruation: ____________ Pap smear: ____________ Mammogram: ___________

Date of last colonoscopy (if over age 50 only): ___________

Signature of Donor: ____ Date: _______________

Office Use Only: Reviewed by: ______________________________ Intake date: ____________

Recipient: ______________________ Relationship: ________________ Status: _______________ ABO: ________