THE QUEEN'S MEDICAL CENTER

LIVING DONOR INTAKE FORM

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

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? _____

If another donor is found for your recipient; would you be interested in learning about donation for someone else on transplant list? ☐ Yes ☐ No

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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

Date of last: Menstruation: _____ Pap smear: _____ Mammogram: _____

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

Have you received COVID vaccination? Y N If yes, Brand: Pfizer/Moderna/J&J, Vaccination dates: _____

Signature of Donor: _____ Date: _____

Staff Use Only: Recipient: _____ Relationship: _____ Status: _____ ABO: _____ PRA: _____
Height: _____ Weight: _____ Dx: _____ Neph: _____