

Carolinas HealthCare System

Potential Living Donor Referral Form

Name:	Dat	e of Birth:	Age:
Address:			
City:	State:	Zip Code:	
Home Phone: C	Cell Phone:		
Best time to contact: Morning (8am-12p	om) Afternoor	n: (12pm-4pm) (ci	rcle one)
Email Address:			
Occupation:	Work Pho	one:	
May we contact you at work: YES	NO		
US Citizen: Yes/ No (circle one)			
Social Security Number:	(for regist	ration purposes onl	y)
Marital Status:			
Height: Weight:	Race:	Sex:	
Do you have children: Yes/No (circle one)	If so, how many a	and ages:	
Emergency Contact:	Relationship:	Phone	:
Recipient Information Recipient Name: Relationship to Recipient: Family (please specified)	Re ecify)	cipient Date of Birth Friend Neighl	n: oor Coworker Other/None
Medical History			
Primary Care Physician Name and Addres 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

High Blood Pressure Diabetes Diabe	Medical (SELF)	Yes	No	Medical (FAMILY)	Yes	No	Relationship
Heart Disease Heart Disease Cancer:type	High Blood Pressure			High Blood Pressure			
Cancer:type When: Lung Issues Lung Issues Lung Issues Tuberculosis/Positive TB skin Tuberculosis/Positive TB skin Tuberculosis/Positive TB skin Anemia Anemia Kidney Stone: year Kidney Stone: year Migraines/Chronic Headaches Migraines/Chronic Seizures Seizures Seizures Sladder Infection Gynecological Issues Lupus Lupus Lupus Dizziness/Memory Loss Stomach/Intestine Issues Stomach/Intestine Issues Prostate Issues Prostate Issues Office Notes: Psychosocial Yes No Body Piercings/Tattoos Office Notes: Alcohol Use: amount per day amount per week amount per week amount per week amount per month History of Depression Cancer: (type) Cancer: (type) Cancer: (type)	Diabetes			Diabetes			
When: Lung Issues Lung Is	Heart Disease			Heart Disease			
Lung Issues Lung Issues Lung Issues Tuberculosis/Positive TB skin Anemia Anemia Anemia Kidney Stone: year Migraines/Chronic Headaches Seizures Bladder Infection Gynecological Issues Lupus Lupus Lupus Dizziness/Memory Loss Stomach/Intestine Issues Herpes Prostate Issues Prostate Issues Do you smoke? If so, how many pack per day amount per week amount per week amount per week amount per week amount per month History of Drug Use History of Depression Lupus Lungs Cynecological Issues Gynecological Issues Gynecological Issues Lupus Cynecological Issues Gynecological Issues Lupus Stomach/Intestine Herpes Prostate Issues Office Notes: Office Notes:	Cancer:type			Cancer: (type)			
Tuberculosis/Positive TB skin Anemia Anemia Anemia Kidney Stone: year Kidney Stone: year Migraines/Chronic Headaches Seizures Bladder Infection Gynecological Issues Lupus Lupus Dizziness/Memory Loss Stomach/Intestine Issues Herpes Prostate Issues Prostate Issues Do you smoke? If so, how many pack per day amount per week amount per week amount per month History of Drug Use History of Depression Kidney Tuberculosis/Positive TB skin Ituberculosis/Positive TB skin Ituberculosis/Positive TB skin Ituberculosis/Positive TB skin Alemia	When:						
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Kidney Stone: year Kidney Stone: year Migraines/Chronic Headaches	Tuberculosis/Positive TB skin						
Migraines/Chronic Headaches Seizures Synecological Issues Lupus Lupus Dizziness/Memory Loss Stomach/Intestine Issues Seizures Sei	Anemia			Anemia			
Seizures Bladder Infection Bladder Infection Gynecological Issues Lupus Lupus Dizziness/Memory Loss Stomach/Intestine Issues Herpes Prostate Issues Prostate Issues Prostate Issues Prostate Issues Prostate Issues Office Notes: Alcohol Use: amount per week amount per wonth History of Drug Use History of Depression Bladder Infection Bladder In	Kidney Stone: year			Kidney Stone: year			
Bladder Infection Gynecological Issues Lupus Lupus Dizziness/Memory Loss Stomach/Intestine Issues Herpes Prostate Issues Psychosocial Do you smoke? If so, how many pack per day amount per week amount per week amount per work History of Drug Use History of Depression Gynecological Issues Gynecological Issues Dizziness/Memory Loss Stomach/Intestine Herpes Ptopical Issues Formatic Issues Formati	Migraines/Chronic Headaches			Migraines/Chronic			
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Lupus Dizziness/Memory Loss Stomach/Intestine Issues Herpes Prostate Issues Psychosocial Do you smoke? If so, how many pack per day amount per week amount per week amount per week amount per month History of Drug Use History of Depression Lupus Dizziness/Memory Loss Stomach/Intestine Herpes Prostate Issues Office Notes: Office Notes:	Bladder Infection			Bladder Infection			
Dizziness/Memory Loss Stomach/Intestine Issues Herpes Prostate Issues Prostate Issues Psychosocial Psychosocial Po you smoke? If so, how many pack per day amount per day amount per week amount per month History of Drug Use History of Depression Dizziness/Memory Loss Stomach/Intestine Herpes Prostate Issues Office Notes: Office Notes:	Gynecological Issues			Gynecological Issues			
Stomach/Intestine Issues Herpes Prostate Issues Prostate Issues Office Notes: Psychosocial Yes No Body Piercings/Tattoos Do you smoke? If so, how many pack per day amount per day amount per week amount per month History of Drug Use History of Depression Stomach/Intestine Herpes Herpes Office Notes: Office Notes:	Lupus			Lupus			
Herpes Prostate Issues Prostate Issues Office Notes: Psychosocial Yes No Body Piercings/Tattoos Do you smoke? If so, how many pack per day amount per dayamount per weekamount per weekamount per month History of Drug Use History of Depression	Dizziness/Memory Loss			Dizziness/Memory Loss			
Prostate Issues Psychosocial Yes No Body Piercings/Tattoos Do you smoke? If so, how many pack per day amount per day amount per week amount per month History of Drug Use History of Depression Prostate Issues Office Notes:	Stomach/Intestine Issues			Stomach/Intestine			
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	Herpes			Herpes			
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	Prostate Issues			Prostate Issues			
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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	Psychosocial	Yes	No				
Alcohol Use: amount per day amount per week amount per month History of Drug Use History of Depression	Body Piercings/Tattoos						
Alcohol Use: amount per day amount per week amount per month History of Drug Use History of Depression	•						
amount per day amount per week amount per month History of Drug Use History of Depression	pack per day						
amount per week amount per month History of Drug Use History of Depression	Alcohol Use:						
amount per month History of Drug Use History of Depression							
History of Drug Use History of Depression							
History of Depression	amount per month						
	History of Drug Use						
History of Bulimia/Anorexia							
	History of Bulimia/Anorexia						

Please list your medications and their of	dosages: (Use additional paper, if	necessary)
Medication	Dosage	How often?
Please list all your surgeries and dates	they occurred: (Use additional pa	per, if necessary)
Surgery	Date	Location
Please have blood pressure check and Date:Taken where If your reading is greater than 140/80,	:	ling/
What is your desired timeframe for do	nation? (Circle one) 3-6mos 6	imos-1year greater than 1year
How did you hear about being a living	donor? (Circle one)	
Family Friends Community Social m	andia place specify	Other place specify
raining Friends Community Social in	ledia, please specify	Other, please specify
I have read and understand the patient answered these questions to the best on at any time about being a living donor.		o me for potential living donors. I have I understand that I can change my mind
At this time, my willingness to donate	on a scale from 1-10 is	
Cignoturo	Data	
Signature:	Date:	
For Office Use Only		
Date Received:	Assigned to: BMI	
	<u> </u>	

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