Records

Living Donor Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2011

Note: These worksheets are provided to function as a guide to what data will be required in the online TIEDI® application. Currently in the worksheet, a red asterisk is displayed by fields that are required, independent of what other data may be provided. Based on data provided through the online TIEDI® application, additional fields that are dependent on responses provided in these required fields may become required as well. However, since those fields are not required in every case, they are not marked with a red asterisk.

Donor ID:

Recipient Center:

Donor Name:

UNOS Donor ID #:

Address: *

Home City: *

State:

Zip Code: -

Home Phone: *

Work Phone:

Email:

SSN: *

Date of Birth: *

Gender: *

- Male
- Female

Marital Status at Time of Donation: *

- Single
- Married
- Divorced
- Separated
- Life Partner
- Widowed
- Unknown

ABO Blood Group:

Donor Type: *

- Biological, blood related Parent
- Biological, blood related Child
- Biological, blood related Identical Twin
- Biological, blood related Full Sibling
- Biological, blood related Half Sibling
- Biological, blood related Other Relative: SPECIFY
- Non-Biological, Spouse
- Non-Biological, Life Partner
- Non-Biological, Unrelated: Paired Donation
- Non-Biological, Unrelated: Non-Directed Donation (Anonymous)
- Non-Biological, Living/Deceased Donation
- Non-Biological, Unrelated: Domino
- Non-Biological, Other Unrelated Directed Donation: Specify

Specify:

Ethnicity/Race: *
(select all origins that apply)

American Indian or Alaska Native

- American Indian
- Eskimo
- Aleutian
- Alaska Indian
- American Indian or Alaska Native: Other
- American Indian or Alaska Native: Not Specified/Unknown

Asian

- Asian Indian/Indian Sub-Continent
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese

- [ ] Asian: Other
- [ ] Asian: Not Specified/Unknown

Black or African American

- [ ] African American
- [ ] African (Continental)
- [ ] West Indian
- [ ] Haitian
- [ ] Black or African American: Other
- [ ] Black or African American: Not Specified/Unknown

Hispanic/Latino

- [ ] Mexican
- [ ] Puerto Rican (Mainland)
- [ ] Puerto Rican (Island)
- [ ] Cuban
- [ ] Hispanic/Latino: Other
- [ ] Hispanic/Latino: Not Specified/Unknown

Native Hawaiian or Other Pacific Islander

- [ ] Native Hawaiian
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Native Hawaiian or Other Pacific Islander: Other
- [ ] Native Hawaiian or Other Pacific Islander: Not Specified/Unknown

White

- [ ] European Descent
- [ ] Arab or Middle Eastern
- [ ] North African (non-Black)
- [ ] White: Other
- [ ] White: Not Specified/Unknown

Citizenship: *

- ○ U.S. CITIZEN
- ○ RESIDENT ALIEN
- ○ NON-RESIDENT ALIEN, Year Entered US

Year of Entry into U.S.: ______

Highest Education Level: *

- ○ NONE
- ○ GRADE SCHOOL (0-8)
- ○ HIGH SCHOOL (9-12) or GED
- ○ ATTENDED COLLEGE/TECHNICAL SCHOOL
- ○ ASSOCIATE/BACHELOR DEGREE
- ○ POST-COLLEGE GRADUATE DEGREE

N/A (< 5 YRS OLD)

UNKNOWN

Did the donor have health insurance: * YES NO UNK

Functional Status: *

Physical Capacity: (check one) *

- No Limitations
- Limited Mobility
- Wheelchair bound or more limited
- Unknown

Working for Income: YES NO UNK

If No, Not Working Due To: (check one)

- Disability
- Insurance Conflict
- Inability to Find Work
- Donor Choice - Homemaker
- Donor Choice - Student Full Time/Part Time
- Donor Choice - Retired
- Donor Choice - Other
- Unknown

If Yes:

- Working Full Time
- Working Part Time due to Disability
- Working Part Time due to Insurance Conflict

Working Part Time due to Inability to Find Full Time Work

Working Part Time due to Donor Choice

Working Part Time Reason Unknown

Working, Part Time vs. Full Time Unknown

Viral Detection:

Have any of the following viruses ever been tested for: HIV, CMV, HBV, HCV, EBV * — YES NO

HIV — YES NO

Test	Result
Screening:	Positive Negative Not Done UNK/Cannot Disclose
Confirmation:	Positive Negative Not Done UNK/Cannot Disclose
Was there clinical disease (ARC, AIDS):	YES NO UNK
Antibody:	Positive Negative Not Done UNK/Cannot Disclose

RNA:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose

CMV	○ YES ○ NO
Test	Result
CMV:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose
Was there clinical disease:	○ YES ○ NO ○ UNK
IgG:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose
IgM:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose
Nucleic Acid Testing:	○ Positive ○ Negative ○ Not Done

UNK/Cannot Disclose

Culture:	Positive Negative Not Done UNK/Cannot Disclose

HBV	YES NO
Test	Result
Was there clinical disease:	YES NO UNK
Liver Histology:	Positive Negative Not Done UNK/Cannot Disclose
Core Antibody:	Positive Negative Not Done UNK/Cannot Disclose
Surface Antigen:	Positive Negative Not Done UNK/Cannot Disclose
HBV DNA:	Positive

	○ Negative ○ Not Done ○ UNK/Cannot Disclose
HDV (Delta Virus):	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose

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HCV	○ YES ○ NO
Test	Result
Was there clinical disease:	○ YES ○ NO ○ UNK
Liver Histology:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose
Antibody:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose
RIBA:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose

HCV RNA:
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

EBV: YES NO

Test	Result
Was there clinical disease:	YES NO UNK
IgG:	Positive / Negative / Not Done / UNK/Cannot Disclose
IgM:	Positive / Negative / Not Done / UNK/Cannot Disclose
EBV DNA:	Positive / Negative / Not Done / UNK/Cannot Disclose

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Pre-Donation Height and Weight

Height: * ft in cm ST=

Weight: * lb kg ST=

History of Cancer: *

- NO
- SKIN - SQUAMOUS, BASAL CELL
- SKIN - MELANOMA
- CNS TUMOR - ASTROCYTOMA
- CNS TUMOR - GLIOBLASTOMA MULTIFORME
- CNS TUMOR - MEDULLOBLASTOMA
- CNS TUMOR - NEUROBLASTOMA
- CNS TUMOR - ANGIOBLASTOMA
- CNS TUMOR - MENINGIOMA
- CNS TUMOR - OTHER
- GENITOURINARY - BLADDER
- GENITOURINARY - UTERINE CERVIX
- GENITOURINARY - UTERINE BODY ENDOMETRIAL
- GENITOURINARY - UTERINE BODY CHORIOCARCINOMA
- GENITOURINARY - VULVA
- GENITOURINARY - OVARIAN
- GENITOURINARY - PENIS, TESTICULAR
- GENITOURINARY - PROSTATE
- GENITOURINARY - KIDNEY
- GENITOURINARY - UNKNOWN
- GASTROINTESTINAL - ESOPHAGEAL
- GASTROINTESTINAL - STOMACH

GASTROINTESTINAL - SMALL INTESTINE

GASTROINTESTINAL - COLO-RECTAL

GASTROINTESTINAL - LIVER & BILIARY TRACT

GASTROINTESTINAL - PANCREAS

BREAST

THYROID

TONGUE/THROAT

LARYNX

LUNG (include bronchial)

LEUKEMIA/LYMPHOMA

UNKNOWN

OTHER, SPECIFY

Specify:

Cancer Free Interval: years ST=

History of Cigarette Use: * YES NO

If Yes, Check # pack years:

0-10

11-20

21-30

31-40

41-50

>50

Unknown pack years

Duration of Abstinence:

- 0-2 months
- 3-12 months
- 13-24 months
- 25-36 months
- 37-48 months
- 49-60 months
- >60 months
- Continues To Smoke
- Unknown duration

Other Tobacco Used: * YES NO UNK

Diabetes: * YES NO UNK

Treatment:

- Insulin
- Oral Hypoglycemic Agent
- Diet

Total Bilirubin: *	mg/dl	ST=
SGOT/AST: *	U/L	ST=
SGPT/ALT: *	U/L	ST=
Alkaline Phosphatase: *	units/L	ST=
Serum Albumin: *	g/dl	ST=
Serum Creatinine: *	mg/dl	ST=
INR: *		ST=

Liver Biopsy: * ○ YES ○ NO

% Macro vesicular fat: [ ] % ST= [ ]

% Micro vesicular fat: [ ] % ST= [ ]

History of Hypertension: *

- ○ NO
- ○ YES, 0-5 YEARS
- ○ YES, 6-10 YEARS
- ○ YES, >10 YEARS
- ○ YES, UNKNOWN DURATION
- ○ UNKNOWN

If Yes, Method of Control:

Diet: ○ YES ○ NO ○ UNK

Diuretics: ○ YES ○ NO ○ UNK

Other Hypertensive Medication: ○ YES ○ NO ○ UNK

Serum Creatinine: * [ ] mg/dl ST= [ ]

Preoperative Blood Pressure Systolic: * [ ] mm/Hg ST= [ ]

Preoperative Blood Pressure Diastolic: * [ ] mm/Hg ST= [ ]

Urinalysis: *

Urine Protein:

- ○ Positive
- ○ Negative

Not Done

Unknown

or

Protein-Creatinine Ratio:

Kidney Biopsy: *

YES NO

Glomerulosclerosis:

0-5

6-10

11-15

16-20

20+

Indeterminate

	Before Bronchodilators		After Bronchodilators	
FVC % predicted: *		ST=		ST=
FEV1 % predicted: *		ST=		ST=
FEF (25-75%) % predicted: *		ST=		ST=
TLC % predicted: *		ST=		ST=
Diffusing lung capacity corrected for alveolar volume % predicted: *		ST=		
PaO2 on room air: *	mm/Hg	ST=		

Type of Transplant Graft: *

- ○ Left Lateral Segment (Peds)
- ○ Left Lobe
- ○ Right Lobe
- ○ Domino Whole Liver

Type of Transplant Graft:

- ○ LEFT KIDNEY
- ○ RIGHT KIDNEY
- ○ EN-BLOC
- ○ Sequential Kidney

Intended Procedure Type: *

- ○ Transabdominal
- ○ Flank(retroperitoneal)
- ○ Laparoscopic Not Hand-assisted
- ○ Laparoscopic Hand-assisted

Conversion from Laparoscopic to Open: ○ YES ○ NO

Type of Transplant Graft:

- ○ LOBE, RIGHT
- ○ LOBE, LEFT

Procedure Type: *

- ○ Open
- ○ Video Assisted Thoracoscopic

Conversion from Thoracoscopic to Open: ○ YES ○ NO

Intra-operative Complications: * ○ YES ○ NO

If Yes, Specify:
- ☐ Sacrifice of Second Lobe Specify
- ☐ Anesthetic Complication Specify
- ☐ Arrhythmia Requiring Therapy
- ☐ Cerebrovasular Accident
- ☐ Phrenic Nerve Injury
- ☐ Brachial Plexus Injury
- ☐ Breast Implant Rupture
- ☐ Other Specify

Sacrifice of Second Lobe, Specify:
- ○ RML
- ○ RUL
- ○ LUL
- ○ Lingular

Anesthetic Complication Specify: ________

Arrhythmia requiring therapy:
- ○ Medical therapy
- ○ Cardioversion

Other Specify: ________

Date of Initial Discharge: * ________

Donor Status: *
- ○ Living
- ○ Dead

Date Last Seen or Death: * ________

Cause of Death:

Other Specify:

Non-Autologous Blood Administration: *

YES NO

If Yes, Number of Units:

PRBC

Platelets

FFP

Biliary Complications: *

YES NO UNK

If Yes, Specify:

Grade 1 – Bilious JP drainage more than 10 days

Grade 2 – Interventional procedure (ERCP, PTC, percutaneous drainage, etc.)

Grade 3 – Surgical Intervention

Date of surgery:

Vascular Complications Requiring Intervention: *

YES NO UNK

If Yes, Specify:

Portal Vein

Hepatic Vein

Hepatic Artery

Pulmonary Embolus

Deep Vein Thrombosis

Other, Specify

Specify:

Other Complications Requiring Intervention: * ○ YES ○ NO ○ UNK

If Yes, Specify:

- ☐ Renal insufficiency requiring dialysis
- ☐ Ascites
- ☐ Line or IV complication
- ☐ Pneumothorax
- ☐ Pneumonia
- ☐ Wound Complication
- ☐ Brachial Nerve Injury
- ☐ Other, specify

Specify: ______

Reoperation: * ○ YES ○ NO ○ UNK

If yes, specify reason for reoperation (during first six weeks):

- ☐ Liver Failure Requiring Transplant Date: ______
- ☐ Bleeding Complications Date: ______
- ☐ Hernia Repair Date: ______
- ☐ Bowel Obstruction Date: ______
- ☐ Vascular Complications Date: ______
- ☐ Other Specify Date: ______

Other Specify: ______

Any Readmission After Initial Discharge: * ○ YES ○ NO ○ UNK

If yes, specify reason for readmission (during first six weeks):

- ☐ Wound Infection
- ☐ Fever

- [ ] Bowel Obstruction
- [ ] Pleural Effusion
- [ ] Biliary Complications
- [ ] Vascular Complications
- [ ] Other, specify

Other Specify: __________

If Yes, Date of First Readmission: __________

Other Interventional Procedures: * ( ) YES ( ) NO ( ) UNK

If Yes, Specify Procedure: __________

Date of Procedure: __________

Vascular Complications Requiring Intervention: * ( ) YES ( ) NO ( ) UNK

If Yes, Specify:

- [ ] Renal Vein
- [ ] Renal Artery
- [ ] Aorta
- [ ] Vena Cava
- [ ] Pulmonary Embolus
- [ ] Deep Vein Thrombosis
- [ ] Other, specify

Specify: __________

Other Complications Requiring Intervention: * ( ) YES ( ) NO ( ) UNK

If Yes, Specify:

- ☐ Renal insufficiency requiring dialysis
- ☐ Ascites
- ☐ Line or IV complication
- ☐ Pneumothorax
- ☐ Pneumonia
- ☐ Wound Complication
- ☐ Brachial Nerve Injury
- ☐ Other, specify

Other Specify:

Reoperation: *

○ YES ○ NO ○ UNK

If yes, specify reason for reoperation (during first six weeks):

- ☐ Bleeding Date:
- ☐ Hernia Repair Date:
- ☐ Bowel Obstruction Date:
- ☐ Vascular Date:
- ☐ Other Specify Date:

Other Specify:

Any Readmission After Initial Discharge: *

○ YES ○ NO ○ UNK

If yes, specify reason for readmission (during first six weeks):

- ☐ Wound Infection
- ☐ Fever
- ☐ Bowel Obstruction
- ☐ Pleural Effusion

- [ ] Vascular Complications
- [ ] Other, specify

Other Specify: ________

If Yes, Date of First Readmission: ________

Other Interventional Procedures: * ○ YES ○ NO ○ UNK

If Yes, Specify Procedure: ________

Date of Procedure: ________

Post-operative complications during the initial hospitalization: * ○ YES ○ NO

If Yes, Specify:

- [ ] Arrhythmia requiring therapy
- [ ] Bleeding requiring surgical or therapeutic bronchoscopic intervention
- [ ] Bowel obstruction or ileus not requiring surgical intervention
- [ ] Bowel obstruction or ileus requiring surgical intervention
- [ ] Bronchial Stenosis/Stricture not requiring surgical or therapeutic bronchoscopic intervention
- [ ] Bronchial Stenosis/Stricture requiring surgical or therapeutic bronchoscopic intervention
- [ ] Bronchopleural Fistula requiring surgical or therapeutic bronchoscopic intervention
- [ ] Cerebrovascular Accident
- [ ] Deep Vein Thrombosis
- [ ] Empyema requiring therapeutic surgical intervention
- [ ] Epidural-Related Complication

- [ ] Line or IV Complication
- [ ] Loculated pleural effusion requiring surgical intervention
- [ ] Pericardial tamponade or pericarditis requiring surgical intervention
- [ ] Pericarditis not requiring surgical intervention
- [ ] Peripheral Nerve Injury
- [ ] Phrenic Nerve Injury
- [ ] Placement of Additional Thoracostomy Tube(s), Specify Indication
- [ ] Pneumonia/Atelectasis
- [ ] Prolonged (>14days) Thoracostomy Tube Requirement
- [ ] Pulmonary Artery Embolus or Thrombosis
- [ ] Pulmonary Vein or Left Atrial Thrombosis
- [ ] Wound Complication
- [ ] Wound infection requiring surgical intervention
- [ ] Other Specify

Arrhythmia requiring therapy:

- ○ Medical therapy
- ○ Cardioversion
- ○ Electrophysiologic Ablation

Placement of Additional Thoracostomy Tube(s), Indication:

- ○ Pneumothorax
- ○ Pleural effusion
- ○ Empyema

Other Specify: ______

Any Readmission After Initial Discharge: * ○ YES ○ NO ○ UNK

If yes, specify reason for readmission (during first six weeks):

- [ ] Wound Infection
- [ ] Fever
- [ ] Bowel Obstruction
- [ ] Pleural Effusion
- [ ] Vascular Complications
- [ ] Other, specify

Specify:

If Yes, Date of First Readmission:

Most Recent Date of Tests:

Height: * ft in cm ST=

Weight: * lb kg ST=

Kidney Post-Operative Clinical Information

Serum Creatinine: * mg/dl ST=

Post-Op Blood Pressure Systolic: * mm/Hg ST=

Post-Op Blood Pressure Diastolic: * mm/Hg ST=

Urinalysis: *

Urine Protein:

- Positive
- Negative
- Not Done
- Unknown

or

Protein-Creatinine Ratio:

Donor Developed Hypertension Requiring Medication: * YES NO UNK

Liver Post-Operative Clinical Information

Total Bilirubin: * mg/dl ST=

SGOT/AST: * U/L ST=

SGPT/ALT: * U/L ST=

Alkaline Phosphatase: * units/L ST=

Serum Albumin: * g/dl ST=

Serum Creatinine: * mg/dl ST=

INR: * ST=

Organ Recovery Date:

Did organ recovery and transplant occur at the same center: * YES NO

Organ(s) Recovered	Recipient Name (Last, First)	Recipient SSN#

Donor Recovery Facility:

Donor Workup Facility:

Comments: