

# 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

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ABO Blood Group:

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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:

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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

Black or African American

- African American
- African (Continental)
- West Indian
- Haitian
- Black or African American: Other
- Black or African American: 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

- Asian: Other
- Asian: Not Specified/Unknown

Hispanic/Latino

- Mexican
- Puerto Rican (Mainland)
- Puerto Rican (Island)
- Cuban
- Hispanic/Latino: Other
- Hispanic/Latino: 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

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Screening:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Confirmation:

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

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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

- Culture:
- UNK/Cannot Disclose
  - Positive
  - Negative
  - Not Done
  - UNK/Cannot Disclose

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

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HCV  YES  NO

Test Result

Was there clinical disease:  YES  NO  UNK

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Liver Histology:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Antibody:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

RIBA:



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

**Pre-Donation Height and Weight**

Height: \*

 ft  in cmST= 

Weight: \*

 lb kgST=

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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

0-10

11-20

21-30

If Yes, Check # pack years:

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

0-5

6-10

11-15

Glomerulosclerosis:

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=

[Empty input field]

- Type of Transplant Graft: \*
- Left Lateral Segment (Peds)
  - Left Lobe
  - Right Lobe
  - Domino Whole Liver

[Empty input field]

- 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

[Empty input field]

- Type of Transplant Graft:
- LOBE, RIGHT
  - LOBE, LEFT
- Procedure Type: \*
- Open
  - Video Assisted Thoracoscopic
- Conversion from Thoracoscopic to Open:
- YES  NO

[Empty input field]

Intra-operative Complications: \*

YES  NO

If Yes, Specify:

Sacrifice of Second Lobe Specify

Anesthetic Complication Specify

Arrhythmia Requiring Therapy

Cerebrovascular 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 cmST= 

Weight: \*

 lb kgST= 

### Kidney Post-Operative Clinical Information

Serum Creatinine: \*

 mg/dlST= 

Post-Op Blood Pressure Systolic: \*

 mm/HgST= 

Post-Op Blood Pressure Diastolic: \*

 mm/HgST= 

Urinalysis: \*

- Positive
- Negative
- Not Done
- Unknown

Urine Protein:

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#
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Donor Recovery Facility:

Donor Workup Facility:

Comments:



