Records

Living Donor Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:

Provider Information

Recipient Center:

Donor Information

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:

- Biological, blood related Parent
- Biological, blood related Child
- Biological, blood related Identical Twin

Donor Type: *

- 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:*	○ **US Citizen** ○ **Non-US Citizen/US Resident** ○ **Non-US Citizen/Non-US Resident, Traveled to US for Reason Other Than Transplant** ○ **Non-US Citizen/Non-US Resident, Traveled to US for Transplant**
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

Pre-Donation Clinical Information

Viral Detection:

Have any of the following viruses ever been tested for: HIV, CMV, HBV, HCV, EBV *	○ YES ○ NO
HIV	○ YES ○ NO
Test	**Result**
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**
Was there clinical disease:	○ YES ○ NO ○ UNK
	○ Positive

	IgG:	○ 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
		○ Positive ○ Negative

Surface Antigen:	○ Not Done ○ UNK/Cannot Disclose
HBV DNA:	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose
HDV (Delta Virus):	○ Positive ○ Negative ○ Not Done ○ UNK/Cannot Disclose

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
	○ Positive

HCV RNA:

- 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 ____ cm ST= ____

Weight: * ____ lb ____ kg ST= ____

- NO
- SKIN - SQUAMOUS, BASAL CELL
- SKIN - MELANOMA
- CNS TUMOR - ASTROCYTOMA
- CNS TUMOR - GLIOBLASTOMA MULTIFORME

History of Cancer: *

- 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

Pre-Donation Liver 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=

Liver Biopsy: *	○ YES ○ NO	
% Macro vesicular fat:	%	ST=
% Micro vesicular fat:	%	ST=

Pre-Donation Kidney Clinical Information

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

Pre-Donation Lung Clinical Information

	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=		

Liver Surgical Information

Type of Transplant Graft: *

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

Kidney Surgical Information

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

Lung Surgical Information

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:

Post-Operative Information

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

Liver Related Post-Operative Complications (In first 6 weeks post-donation)

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:

Kidney Related Post-Operative Complications (In first 6 weeks post-donation)

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:

Lung Related Post-Operative Complications (In first 6 weeks post-donation)

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:

Post-Operative Clinical Information (Within 6 weeks post-donation)

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

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:		