Living Donor Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 08/31/2023

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:

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: Domino
- Biological, blood related: Non-Domino Therapeutic donor
- 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, Unrelated: Domino
- Non-Biological, Unrelated: Non-Domino Therapeutic donor
- Non-Biological, Other Unrelated Directed Donation: Specify
- Non-Biological, Living/Deceased Donation (Inactive)

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**
Country of Permanent Residence:	
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

Test	Result
HIV Status:	Positive / Negative / Not Done / UNK/Cannot Disclose
CMV	
Total:	Positive / Negative / Not Done / UNK/Cannot Disclose
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
HBV	
DNA (NAT/PCR):	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
HCV	

	RNA (NAT/PCR):	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**
	Antibody:	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**
	RIBA:	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**
EBV		
	Total:	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**
	IgG:	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**
	IgM:	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**

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

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:

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
- Left Lobe without MHV (Middle Hepatic Vein)
- Left Lobe with MHV
- Right Lobe without MHV
- Right Lobe with MHV
- Domino Whole Liver
- Domino Partial Liver

Kidney Surgical Information

Type of Transplant Graft:

- Left Kidney
- Right Kidney
- En-Bloc
- Dual Kidney
- Hemi-Renal

Intended Procedure Type:*

- Transabdominal
- Flank(retroperitoneal)
- Laparoscopic Not Hand-assisted
- Laparoscopic Hand-assisted
- Natural Orifice

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 (At discharge or 6 weeks, whichever occurs first)

Biliary Complications: *	○ **YES** ○ **NO**
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**
If Yes, Specify:	☐ **Portal Vein** ☐ **Hepatic Vein** ☐ **Hepatic Artery** ☐ **Pulmonary Embolus** ☐ **Deep Vein Thrombosis** ☐ **Other, Specify**
Specify:	
Other Complications Requiring Intervention: *	○ **YES** ○ **NO**

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 (At discharge or 6 weeks, whichever occurs first)

Vascular Complications Requiring Intervention: * ○ **YES** ○ **NO**

If Yes, Specify:

- ☐ **Renal Vein**
- ☐ **Renal Artery**
- ☐ **Aorta**
- ☐ **Vena Cava**
- ☐ **Pulmonary Embolus**
- ☐ **Deep Vein Thrombosis**
- ☐ **Other, specify**

Specify:

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

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 (At discharge or 6 weeks, whichever occurs first)

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 (At discharge or 6 weeks, whichever occurs first)

Most Recent Date of Tests:

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:

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

Donor Recovery Facility:

Donor Workup Facility: