Records

Living Donor Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 07/31/2020

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

Hispanic/Latino
- ☐ Mexican
- ☐ Puerto Rican (Mainland)
- ☐ Puerto Rican (Island)

- [ ] 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

- [ ] 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: *

- ○ **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
- Sequential 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:

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