Northwestern Memorial® Hospital

POTENTIAL LIVING DONOR KIDNEY QUESTIONNAIRE

FAX (312) 926-5629 | Phone (312) 695-0828

SPOKEN LANGUAGE: _____ Preferred Language: _____

DATE: _____ SS#: _____ GENDER: _____

DONOR LAST NAME: _____ DONOR FIRST NAME: _____

Donor Address: _____

City, State, Zip: _____

Home Phone: _____ Work: _____ Cell : _____

DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

Potential Donor to (Recipient Full Legal Name): GARY GREENBERG 01.15.40

Relationship to Recipient: BJBE ABO: _____

Part 1 - Donor Medical Information

MEDICATIONS / DOSAGE	HERBAL SUPPLEMENTS	ALLERGIES TO MEDICATIONS

MEDICAL TESTING	DATE OF LAST	DOCTOR'S NAME AND PHONE NUMBER:
PHYSICAL		
MAMMOGRAM		
PAP SMEAR		
PROSTATE SPECIFIC ANTIGEN (PSA)		

PART 2- DO YOU HAVE OR EVER HAD? PLEASE CHECK YES OR NO

	YES	NO			YES	NO
DIABETES:				HIGH BLOOD PRESSURE:		
KIDNEY STONES:			HOW MANY TIMES? _____	CHRONIC LUNG DISEASE:		
CANCER:				HEART DISEASE:		
ACTIVE HEPATITIS:				ARE YOU PREGNANT? OR TRYING?:		
LUPUS:				GESTATIONAL DIABETES:		

PART 3- DO YOU HAVE OR EVER HAD? PLEASE CHECK YES OR NO AND FILL-IN AMOUNT AND FREQUENCY

	YES	NO		YES	NO	AMT/FREQ.
ASTHMA:			ALCOHOL:			
ANEMIA:			SMOKE:			
HIGH CHOLESTEROL:			QUIT SMOKING:			WHEN?
BLOOD TRANSFUSION:			ILLICIT IV DRUGS:			
SEIZURES:			MARIJUANA:			
HEART MURMUR:			COCAINE:			
URINARY TRACT INFECTION UTI:			TATTOO OR BODY PIERCING:			
KIDNEY OR BLADDER INFECTION:			IRREGULAR PAP SMEAR:			(WOMEN ONLY)
PROTEIN IN URINE:			IRREGULAR MAMMOGRAM:			
BLOOD URINE:			ELEVATED PSA:			(MEN ONLY)
TUBERCULOSIS			DESPRESSION, ANXIETY, PANIC ATTACK:			
			PSYCHIATRIC DISORDER:			

Donor Last Name: _____ **First Name:** _____

Part 4 – Donor Surgical and Hospitalization History

Please list any surgical procedures you have had in the past.

Surgical Procedure	Date	Reason(s) Performed

Have you every been hospitalized for any reason other than the above surgery? Yes ☐ No ☐

Reason(s) for Hospitalization	Date of Hospitalization	Diagnosis

Part 5 – Has anyone in your family ever had: please check YES or NO and indicate relative, i.e. mother , father, sister, brother, etc.

	Yes	No	Relative?
High Blood Pressure:	☐	☐	
Heart Attack or Stroke:	☐	☐	
Coronary Artery Disease:	☐	☐	
Diabetes:	☐	☐	
Cancer:	☐	☐	

	Yes	No	Relative?
Kidney Disease	☐	☐	
Transplanted?	☐	☐	
On Dialysis?	☐	☐	

Age of Onset? _____

Type of Cancer? _____

Part 6 – Additional Questions, Please check YES or No

	Yes	No
Are you married?	☐	☐
Is your spouse aware of your interest to donate:	☐	☐
Are you ready to donate?	☐	☐

Do you have any additional questions about being a live kidney donor? _____

Where were you born? _____

Where did you grow up? _____

What is your country of citizenship? _____

How would you rate your family support system?

Excellent ☐ Fair ☐

No Support ☐ Against Donation ☐

How many children do you have? _____ Ages of your children? _____

Have you talked to your employer about giving you time off work to be a kidney donor? Yes ☐ No ☐

Have you ever consulted a psychiatrist or felt the need to see one? Yes ☐ No ☐

Who will be able to take care of you after your kidney donor surgery? _____

Part 7 – Additional Questions, Please check YES or No

What is your highest level of education completed? Grade School (0-8) ☐ High School (9-12) ☐

College/Technical School? ☐ Associate/Bachelor Degree ☐ Post-College Graduate Degree ☐

Are you currently working for income/money? Yes ☐ No ☐ Retired ☐

If yes, Full-Time ☐ Part-Time due to demands of transplant ☐ Part-Time due to disabilty? ☐

Part-Time due to inability to find Full-time Work ☐ Part-Time Patient choice ☐

Employer: _____

Occupation: _____

Potential Kidney Donor Questionnaire

DONOR LAST NAME: _____ **FIRST NAME:** _____

PART 8 – ADDITIONAL QUESTIONS:

WHAT IS YOUR RACE/ETHNICITY (CHECK ALL THAT APPLY) ☐ MOTHER'S/FATHER'S RACE ETHNICITY: ☐

☐	AFRICAN AMERICAN	☐	AFRICAN AMERICAN
☐	ALEUTIAN	☐	ALEUTIAN
☐	ARAB MIDDLE EAST	☐	ARAB MIDDLE EAST
☐	ASIAN INDIAN	☐	ASIAN INDIAN
☐	CAUCASIAN	☐	CAUCASIAN
☐	CHINESE	☐	CHINESE
☐	CUBAN	☐	CUBAN
☐	ESKIMO	☐	ESKIMO
☐	EUROPEAN ANCESTRY	☐	EUROPEAN ANCESTRY
☐	FILIPINO	☐	FILIPINO
☐	GUAMANIAN OR CHAMORRO	☐	GUAMANIAN OR CHAMORRO
☐	HAITIAN	☐	HAITIAN
☐	HISPANIC (OTHER)	☐	HISPANIC (OTHER)
☐	INDIAN ALASKA	☐	INDIAN ALASKA
☐	JAPANESE	☐	JAPANESE
☐	KOREAN	☐	KOREAN
☐	MEXICAN	☐	MEXICAN
☐	NATIVE HAWAIIAN	☐	NATIVE HAWAIIAN
☐	PUERTO DE LA ISLA	☐	PUERTO DE LA ISLA
☐	PUERTO RICAN	☐	PUERTO RICAN
☐	SAMOAN	☐	SAMOAN
☐	VIETNAMESE	☐	VIETNAMESE
☐	OTHER	☐	OTHER

HOW DID YOU RECEIVE THIS QUESTIONNAIRE?

- ☐ ATTENDED DONOR EDUCATION SESSION
- ☐ GIVEN TO ME BY THE RECIPIENT
- ☐ RECEIVED IN THE MAIL FROM THE TRANSPLANT DEPARTMENT

HAVE YOU RECEIVED DONOR EDUCATION MATERIALS FROM NORTHWESTERN?

☐ YES ☐ NO ☐ NOT SURE

- I am willing to donate.
- I am not being paid to donate my organ.
- I am not being forced to donate my organ.
- I understand that I may decline to donate at any time.
- I understand that if I decline to donate, NMH will keep this completely confidential.
- I understand that an Independent Donor Advocate (IDA) will help me through the process.
- I am aware that it is a federal crime for any person to knowingly acquire, obtain, or otherwise transfer any human organ for anything of value such as cash, property, vacations, or other valuable consideration.

PATIENT SIGNATURE: _____

Northwestern Memorial® Hospital

Kovler Organ Transplantation Center

Donor Financial Letter

As a potential living kidney donor, several tests are required to ensure that you are in optimal good health to be an organ donor. The standard donor tests that are covered by your recipient's insurance are an EKG, chest x-ray, CT scan, 24 hour urine, blood work, and occasionally an echocardiogram. Based on those test results, it is possible that our physicians will recommend that your primary care physician order additional testing. This testing is a necessary health screening that you would need regardless of donation status. If the testing indicates a problem, you will need to have your primary care physician recommend treatment. Any additional testing and treatment will be your responsibility and will need to be paid for out of pocket or be billed under your insurance. This may include, but is not limited to, stress tests and ultrasounds.

If you are approved to be a kidney donor, the cost for your surgery and routine post donor follow-up visits at 1 week, 6 months, 1 year, and 2 years will not be your responsibility. Though uncommon, you may have donor-related complications and need to have additional appointments or treatments at Northwestern Memorial Hospital (NMH) for care. The costs associated with complications treated at NMH will also not be your responsibility.

The two most common complications seen at Northwestern Memorial Hospital (NMH) are developing a hernia at the area of the incision, which occurs 0.002% of patients, or the need for the scar to be surgically revised due to pain or non-healing, again occurring in only 0.002% of patients.

At anytime during your evaluation or after donation, if you receive a bill from Northwestern Memorial Hospital (NMH) or any other facility for donation related services please send it to us **immediately**. Do not discard it or ignore it! **If you receive a bill, it means that we did not receive it and cannot pay it**. Mail the itemized invoice to:

Kovler Organ Transplantation Center
Attn: Financial Analyst
676 N. Saint Clair Street
Suite #1900
Chicago, IL 60611

Northwestern Memorial Hospital and Northwestern Memorial Faculty Foundation will bill the recipient's insurance for complications ONLY if the care provided at NMH unless it is a life-threatening emergency. The determination that a problem is donation-related complication is at the discretion of a transplant surgeon. **Please note: We cannot cover care received at another hospital without the express permission of the director prior to the care being delivered.** Without this permission, we will expect that your own insurance will be billed for services provided at non-NMH facilities.

It is our goal that you will not have financial difficulties because of the donation and it is important for you to understand that you will never be denied medical care related to your donation because of your financial situation.

I have read and understand the above and my questions have been answered. I fully agree to each of the statements in this form and sign below as my free and voluntary act.

Signature of Patient _____ Date _____

Northwestern Memorial® Hospital

AUTHORIZATION TO OBTAIN INFORMATION

Print Patient's Name_____

Address_____ **City/State/Zip**_____

Date of Birth ____/____/_____ **Social Security Number** _____-_____ -_____ **Phone ( )**_____

I _____ **hereby authorize** _____

❑ **To release (written/oral/electronic) information to:**

Northwestern Memorial Hospital
Solid Organ Transplantation Program
676 North Saint Clair Street, Suite 1900
Chicago, Illinois 60611
Phone: 312-695-0828
Fax: 312-695-0036

INFORMATION TO BE RELEASED

❑ Discharge Summary ❑ Operative Reports ❑ Pathology Reports ❑ Radiology Reports

❑ Radiology ❑ Lab Reports ❑ Clinic/Office Record ❑ Evaluations/psychological testing

❑ Treatment Planning Form ❑ Consultations ❑ Integrated Assessment ❑ Slides

❑ Record Abstract (History and Physical, Progress Notes, Lab, Radiology, Operative Report, Pathology Report, Consultation Report and other diagnostic tests)

❑ Other (Please specify) _____

Concerning the care of the above patient from dates _____ to _____

This should include sensitive information such as mental, substance abuse, or HIV/AIDS unless checked below.

❑ **Mental Health** ❑ **Substance Abuse** ❑ **HIV/AIDS** ❑ **Other** _____

These records are obtained for the purpose of

❑ **Continuity of Care** ❑ **Other**

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time in writing except to the extent that records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended.

_____

Signature: Patient or Legally Authorized Patient Representative Date of Signature

_____

Relationship to Patient

_____

Signature of Witness Date of Signature

The Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

The Federal Confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.
A general authorization for the release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR41997. Nov. 2, 1987]. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization

Northwestern Memorial® Hospital

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information; please complete the following which tells us how you wish to be contacted.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home Telephone Number _____
  - ❑ Do not contact me at home
  - ❑ Leave message with department/office name and call-back number on answering machine
  - ❑ Leave message with medical information on answering machine
  - ❑ Give information to family member(s)

- ❑ Work Telephone Number _____
  - ❑ Do not contact me at work
  - ❑ Leave message with department/office name and call-back number on voicemail
  - ❑ Leave message with medical information on voicemail
  - ❑ Communicate medical information to co-workers/assistant

- ❑ Written Communication
  - ❑ Do not send written medical information to me
  - ❑ Mail information to my home address on file
  - ❑ Mail to my work/office address on file
  - ❑ Mail information to other address: List _____
  - ❑ Fax to the following number _____

- ❑ E-Mail Communication
  - ❑ I do not want to communicate by E-mail
  - ❑ You can communicate via E-mail with me at _____
    Patient Authorization Form on the reverse side must also be signed

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By your signature below, you agree to be communicated in the above manner.

Patient Signature _____ Date _____

PATIENT AUTHORIZATION TO USE E-MAIL
FOR COMMUNICATION OF CLINICAL INFORMATION

I hereby authorize Northwestern Memorial Hospital (including any affiliates, subsidiaries, and any entities in which Northwestern Memorial Hospital or its affiliates of subsidiaries has an interest) (collectively, "NM") to utilize electronic mail to communicate clinical information to me pertaining to health care services that have been rendered to me ("E-Mail"). I acknowledge and understand that such E-Mail may contain personal and private medical information of mine including, but not limited to, my name, address, social security number, date of birth, race and ethnicity demographics, mother's maiden name, types and dates of health care services received, name and address of the provider administering each health care services, insurance coverage information and/or test results (the "Medical Records").

I acknowledge and understand that, although NM may engage in certain practices in order to protect the privacy of the contents of any E-Mail sent to me and will take all reasonable measures to protect my privacy, the E-Mail messages sent to me are not encrypted and travel over the Internet and, as a result, there is a risk that the E-Mail will be intercepted and read by third parties to whom the E-Mail is not directed. In authorizing NM to send me E-Mail, I assume the foregoing risk.

I understand that E-Mail is not an appropriate medium for conveying information relating to urgent or emergency medical matters and that I will use the telephone as my means of communication with NM or any other appropriate health care provider as the situation may warrant.

I understand that, by authorizing NM to send me E-Mail, certain employees and agents of NM may have access to my e-mail address and E-Mail content, such as triage nurses, consulting physicians and other health care providers that are permitted access to my medical records.

I acknowledge that I, and not NM, am responsible for the security of E-Mail communications sent from or stored on my computer or information system, including, but not limited to, protecting access to any E-Mail stored my computer or information system, implementing security measures when delivering E-Mail from my computer or information system and implementing virus protection on my computer or information system.

I hereby authorize NM to retain my e-mail address in its databases so that it may send me future communications regarding its services, fund raising activities and other matters relating to NM's business. I understand that I may revoke this authorization at any time by providing written notice, electronically or otherwise to Gwen McNatt, Manager of Transplant Clinic, at 675 N. St. Clair, Suite 1720, Chicago, Illinois, 60611. I acknowledge that NM will only use my e-mail address for NM business purposes and that it will not sell, transfer or otherwise disclose my e-mail address or any of my other personal information to any third parties without my prior consent.

I understand that my decision to permit NM is voluntary, and that treatment is not conditioned upon my election to do so.

I understand that I may revoke this authorization at any time by providing written notice, electronically or otherwise, to NM's Transplant Clinic.

I understand and agree not to hold NM liable for any damages resulting from their use of E-Mail in accordance with the terms of this authorization or the failure in any manner of any Northwestern Memorial information systems used to facilitate the delivery of such E-Mail.

English is my primary spoken and written language and I fully understand the meaning of this authorization.

A photostatic or facsimile copy of this authorization is valid as the original.

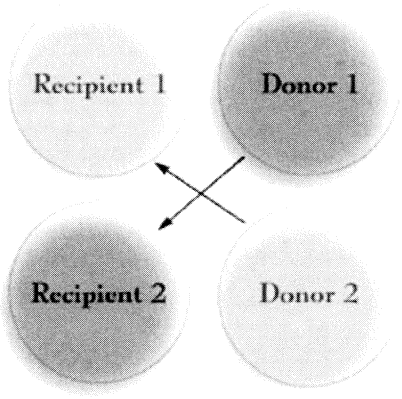
Print Name _____

Patient Signature _____

Date _____

Paired Kidney Exchange
for
Living Donor Kidney Transplantation

Some potential live kidney donors are unable to donate to their recipient because they are NOT compatible. The Paired Kidney Exchange Program allows patients who have willing but incompatible donors to "exchange" kidneys so that both patients get transplanted and both donors give kidneys – the kidneys just go to different recipients than usually expected.



Please indicate your level of interest in the Paired Kidney Exchange Program below and mail this page back with your Donor Health Questionnaire material.

1. If I am NOT compatible with my potential transplant recipient, I would like to find out more about how we could be paired with another family in order to help my recipient get a kidney transplant.

   (circle one) **Yes** – I'd like more information **No** – not interested

2. Even if I AM compatible with my potential transplant recipient, I would like to hear more about being paired with another family to help 2 patients get kidney transplants.

   (circle one) **Yes** – I'd like more information **No** – not interested

Donor name _____ Date_____

Recipient Name _____ Date_____