LIVING DONOR PATIENT INFORMATION
(MUST BE COMPLETED AND RETURNED WITHIN ONE WEEK OF RECEIVING)

Name: _____ **Date:** _____

Address: _____ **City**_____ **State**_____ **Zip**_____

Contact Phone Number: _____

How many miles from your home is the Oklahoma Transplant Center? _____

INSURANCE PROVIDER **(Check all that apply)**

- ☐ Medicare ☐ Medicaid/Sooner Care ☐ ACA Plan ☐ Indian Health ☐ Commercial Insurance ☐ Other_____

RECIPIENT INFORMATION

- Name of Recipient _____
- Relationship to Recipient _____
- If you were not a match to the recipient would you be interested in learning more about paired donation? _____

FAMILY BACKGROUND (Please provide their name and phone number)

- Marital/Relationship Status: ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Other**_____
  Name: _____
- Parents: _____
- Siblings: _____
- Children: _____
- Are you the primary caregiver for anyone else? (If yes, who will assist with their care when you are unable to?) _____
  _____
- Additional Support: _____

TRANSPORTATION

- Do you have a valid license? ☐ Yes ☐ No
- Do you drive? ☐ Yes ☐
- Do you have any issues driving at night, or in the city? ☐ Yes ☐ No
- How do you get to and from medical appointment, grocery store, etc? _____
- Do you have access to and/or utilize sooner ride or sooner ride mileage reimbursement? ☐ Yes ☐ No

RELIGIOUS/SPIRITUAL

- Do you belong to a religious/spiritual community? (Church, Temple, Mosque, Synagogue) ☐ Yes ☐ No
- Do you have any personal, religious or spiritual beliefs that would hinder your healthcare in any way? ☐ Yes ☐ No

HOME ENVIRONMENT

- Type of Residence (Check all that apply) ☐ Mobile Home ☐ Apartment ☐ Single Family Home ☐ Nursing Home ☐ Assisted Living ☐ Section 8 Housing ☐ Other_____
- Who lives in your home with you? _____
- Do you have any pets? ☐ Yes ☐ No
- Do you have any stairs? ☐ Yes ☐ No
- Are you bedroom and bathroom on the same floor? ☐ Yes ☐ No
- Do you have working heat and air conditioning? ☐ Yes ☐
- Do you have running water? ☐ Yes ☐ No
- Do you have any structural damage? (Leaking windows/roof, mold, etc.) ☐ Yes ☐ No
- Do you have any assistive devices in the home? (Ramps, grab bars, lift chairs, etc.) ☐ Yes ☐ No

EMPLOYMENT/RETIREMENT/DISABILITY (Check all that apply)

- ☐ Full time ☐ Part time ☐ Retired ☐ Student ☐ Unemployed ☐ SSI ☐ SSDI ☐ Military Disability ☐ Short-term disability ☐ Long-term disability ☐ Workers Comp ☐ Unemployed ☐ Looking for work
- Name of current or last employer_____ Start Date: _____ End Date:_____
- Do you have access to: ☐ Paid time off ☐ FMLA ☐ Short-term disability ☐ Long-term disability ☐ N/A
- Do you plan to return to work after transplant? ☐ Yes ☐ No ☐ N/A
- Do you have any concerns about your job post-transplant? ☐ Yes ☐ No ☐ N/A
- How do you plan to cover your expenses while off work? _____
- If you are on disability, what is your disability based on and when were you deemed disabled? _____ _____

FINANCIAL

- Is your current income enough to pay monthly living expenses? ☐ Yes ☐ No
- How will your cover your monthly expenses and incidental expenses while you are off work? _____ _____
- What is your financial plan should you have to be off work longer than expected? _____
- How do you manage when you do not have enough money during the month? _____
- Do you receive food stamps? ☐ Yes ☐ No
- Do you have any payday loans/finance loans? ☐ Yes ☐ No
- Will your caregiver being off work have an effect on your income? ☐ Yes ☐ No
- Have you ever filed for bankruptcy? ☐ Yes ☐ No

MILITARY SERVICE

- Have you served in the military? ☐ Yes ☐ No Branch: _____ Years of Service: _____ Discharge Disposition: _____
- Were you involved in active combat? ☐ Yes ☐ No
- Do you use a VA Clinic? ☐ Yes ☐ No ☐ N/A

EDUCATION

- What was the highest grade you completed in school? ☐ High school ☐ GED ☐ Grade_____
- Do you have an additional education? ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Trade/VoTech
- Do you have any plans for continued education? ☐ Yes ☐ No
- Are you able to read/write/comprehend English? ☐ Yes ☐ No
- During school were you in any special education classes or having any learning disabilities? ☐ Yes ☐ No
- What is your native language? _____
- Do you read/write/comprehend in your native language? ☐ Yes ☐ No
- Do you require an interpreter? ☐ Yes ☐ No

CITIZENSHIP

- Where you born in the United States? ☐ Yes ☐ No (If yes, skip to next section)
- What year did you move to the US? _____
- What is your current citizenship status? ☐ Permanent Resident ☐ Naturalized Citizen ☐ Undocumented ☐ Work/Student Visa
- Date of Approval: _____ Date of Expiration: _____
- Do you have any outstanding citizenship concerns? ☐ Yes ☐ No

ADVANCED DIRECTIVES/GUARDIANSHIP/LEGAL NEXT OF KIN

- Are you able to make your own healthcare/financial decisions? ☐ Yes ☐ No
- Do you have a legal guardian/representative payee? ☐ Yes ☐ No
- Do you have an Advance Directive? ☐ Yes ☐ No (If yes, please bring copy to your appointment)
- Do you have a DPOA for Healthcare or Finances? ☐ Yes ☐ No (If yes, please bring copy to your appointment)

MEDICAL/ADHERANCE

- Do you have any current or previous other health issues? ☐ Yes ☐ No
- Do you have a Primary Care Provider (Someone you see for colds, etc?) ☐ Yes ☐ No
- How do you manage your medications? ☐ Memory ☐ List ☐ Pillbox ☐ Caregiver ☐ Other_____
- Do you have any difficulties in getting or taking your medications? ☐ Yes ☐ No
- Have you ever changed the way you take a medication without talking to the doctor? ☐ Yes ☐ No

FUNCTIONAL ABILITY/PERSONAL CARE

- What physical changes/declines/improvements have you seen in the last 6 months? _____
- Do you have any issues with your (check all that apply) ☐Vision ☐ Speech ☐ Hearing
- Do you use ☐Walker ☐ Wheelchair ☐ Cane ☐ Shower Chair ☐ Bedside Commode ☐ Electric Wheelchair/Scooter
- Do you exercise? ☐ Yes ☐ No
- Are you able to complete basic household tasks? ☐ Cook ☐ Clean ☐ Laundry ☐ Yard Work ☐ Grocery Shopping
- Are you able to bathe and groom yourself? ☐ Yes ☐ No
- Please describe your greatest physical limitation(s) _____

COGNITIVE FUNCTIONING/HEALTH LITERACY

- How do you best learn new information (check all that apply)? ☐ Reading ☐ Verbal ☐ Personal research ☐ Family explanation ☐ Medical explanation ☐ Hands-on ☐ Other _____
- Do you have any history of developmental delays/learning differences/special education? ☐ Yes ☐ No
- Do you have any current or past medical issues that have affected your cognitive functioning? ☐ Yes ☐ No
- Have you noticed any problems or changes in attention span, disorientation, or ability to manage medical regimen? ☐ Yes ☐ No

MENTAL HEALTH and DEPRESSION

- Do you now or have you in the past had a history of (check all that apply) ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Bipolar Disorder ☐ Anorexia ☐ Bulimia ☐ ADHD ☐ PTSD ☐ Personality Disorder
- Have you ever been abused (check all that apply) ☐ Physically ☐ Emotionally ☐ Sexually
- Have you ever attempted suicide or thought about harming yourself or others? ☐ Yes ☐ No
- Have you ever been hospitalized in a psychiatric hospital? ☐ Yes ☐ No
- Do you currently or have you ever seen a therapist/counselor/psychiatrist? ☐ Yes ☐ No
- Have you used medications for mental health issues, sleep and/or pain now or in the past? ☐ Yes ☐ No

COPING STRATEGIES

- Do you have any current stressors in your life? ☐ Yes ☐ No
- What are your coping strategies for dealing with stressful situations? _____
- Have you had major surgery in the past? ☐ Yes ☐ No
- Did you have any physical, emotional, or financial complications after surgery? ☐ Yes ☐ No

SUBSTANCE USE/ABUSE/DEPENDENCE

- Do you currently smoke, use chewing tobacco, or vapor/e-cigarettes? ☐ Yes ☐ No
- Have you ever smoked or used chewing tobacco? ☐ Yes ☐ No
- Do you currently drink alcohol? ☐ Yes ☐ No
- Have you ever consumed alcohol? ☐ Yes ☐ No
- Do you currently use any illegal drugs? ☐ Yes ☐ No
- Have you ever used illegal drugs? ☐ Yes ☐ No
- Do you currently abuse prescription drugs? ☐ Yes ☐ No
- Have you ever abused prescription drugs? ☐ Yes ☐ No
- Have you ever been to an alcohol/drug treatment program? ☐ Yes ☐ No
- Does anyone in your family have a history of drug or alcohol abuse? ☐ Yes ☐ No

LEGAL ISSUES

- Are you currently or have you ever been on probation or parole? ☐ Yes ☐ No
- Do you have any current pending legal issues? ☐ Yes ☐ No
- Do you have or have you ever had any warrants out for your arrest? ☐ Yes ☐ No

- Have you had any substance related legal problems? ☐ Yes ☐ No
- Do you have any current child support concerns? ☐ Yes ☐ No
- Do you have a valid driver's license? ☐ Yes ☐ No

KNOWLEDGE AND UNDERSTANDING OF DONATION PROCESS/RISKS AND BENEFITS

- Do you know anyone else that has donated an organ? ☐ Yes ☐ No
- Do you understand the long/short term medical risks of donation for the donor? ☐ Yes ☐ No
- Do you understand the long/short term medical risks of donation for the recipient? ☐ Yes ☐ No
- What is your biggest concern regarding donation? _____
- Do you understand the long/short term psychosocial risks (financial, emotional, etc.) of donation for the donor? ☐ Yes ☐ No
- Do you understand the long/short term psychosocial risks (financial, emotional, etc.) of donation for the recipient? ☐ Yes ☐ No
- What is your understanding of the recovery process? _____
- Do you feel the donation will interfere with your lifestyle or every day activities? ☐ Yes ☐ No

WILLINGNESS AND DESIRE TO DONATE

- Why do you want to donate? _____
- How does your family/friends feel about your desire to donate? _____
- How did you find out about the need for donation? _____
- How did you become the donor? ☐ Volunteered ☐ Was Asked ☐ Other _____
- How does the recipient feel about your desire to donate?_____
- Do you think your relationship with the recipient will change after donation? ☐Yes ☐ No