FLORIDA HOSPITAL

Thank you for your interest in living kidney donation. Enclosed you will find some basic information regarding the evaluation process and a three-page application to complete and return. Please return the application in one of the following ways:

- Mail: FHTI Living Donor Program 2415 North Orange Avenue, Suite 700, Orlando, FL 32804
- Fax: Attn Central Intake (407) 303-0894
- Email: FHTI.Centralized.Intake@FLHosp.org

Candidates for living kidney donation must be willing to donate of their own free will and without the influence of outside pressure. There is no maximum age limit for donation but you must be at least 18 years of age. Donors must be healthy and free from chronic conditions such as heart disease, cancer, or other serious medical conditions that could place them at higher risk for surgical or long-term complications from donation. We will screen each application carefully and let you know if you meet the criteria to begin the process of evaluation.

The evaluation does require a visit to the Florida Hospital Transplant Institute to meet with the living donor team and physicians, however some testing such as the compatibility can be done by mail if you live out of the area.

The evaluation, surgery, and hospitalization for donation are covered by the recipient's insurance through the transplant center. Some age-appropriate cancer screenings may be required and unfortunately are not covered through the donation process. These would include: Pap-smear, mammogram, and colonoscopy. Travel expenses, lost wages, and lodging are also not covered by insurance and are the responsibility of the donor and recipient. The National Living Donor Assistance Center may be able to assist donors living outside the area with the cost of travel and lodging. Applications are available through the Living Donor Program.

If you are not found to be compatible with your potential recipient, we have a Paired Donation Program where we list you as a pair in two databases that help to find compatible matches for you and your recipient. The kidney donor and kidney recipient have surgery on the same day. We partner with the Alliance for Paired Donation and the Organ Procurement and Transplant Network's Kidney Paired Donation Program.

Our donor evaluations are kept confidential and not shared with your potential recipient. We do advise you to keep them informed of your progress throughout the evaluation. Once your application is processed by our Intake Coordinator, the evaluation coordinator will contact you directly to discuss the next steps. We look forward to working with you!

Sincerely,

Florida Hospital Transplant Institute

Living Donor Program

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FLORIDA HOSPITAL

Living Kidney Donor Application

(407) 303-3622 | (407) 303-0681 FAX

Patient Demographics:

Legal Name:

First: _____ M.I.: _____ Last: _____

DOB: ☐☐/☐☐/☐☐☐☐ Age: _____ Sex: ☐ Male ☐ Female

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐

Social Security#: ☐☐☐-☐☐-☐☐☐☐ Email: _____

Medical Insurance: ☐ Yes ☐ No Name of Insurance: _____

Primary Care Physician: _____

Highest Education Level: ☐ None ☐ Grade School ☐ High School or GED ☐ Attended College/Technical School ☐ Associate/Bachelor Degree ☐ Post-College Graduate Degree

Preferred Language: _____

Ethnicity/Race: ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Other: _____

U.S. Citizen: ☐ Yes ☐ No ☐ Legal Resident ☐ Visa Type of Visa: _____

Name of person you want to donate to: First: _____ M.I.: ____ Last: _____

What is your relationship with the patient: ☐ Parent ☐ Step-Parent ☐ Child ☐ Step-Child ☐ Full Sibling ☐ Half Sibling ☐ Step-Sibling ☐ Identical Twin ☐ Friend ☐ Co-Worker ☐ Met on Social Media ☐ Other: _____

Social History:

Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Homemaker ☐ Disabled ☐ Student

Occupation: _____

Children: ☐ Yes ☐ No If yes, how many: _____ Ages: _____

Who would be available to help you after surgery and what is their relationship to you? After surgery, you may need help with child care, travel to appointments, or finances when taking time off work: _____

Use of alcohol: ☐ Never ☐ Socially ☐ Weekly ☐ Daily Amount and type: _____

History of cigarette use: ☐ Yes ☐ No If yes, how many packs per day? _____ How many years? _____

When did you quit? _____ Other tobacco used: ☐ Yes ☐ No Type: _____

Recreational drugs: ☐ Never ☐ Socially ☐ Regularly Quit/year: _____ Drug(s) used: _____

Medical History:

	Patient	Family History
Abnormal blood sugar/Diabetes/Gestational	☐ Yes ☐ No	☐ Yes ☐ No
Comment: _____		Relationship to you: _____
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
How many years of high blood pressure: _____		Relationship to you: _____
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No
Comment: _____		Relationship to you: _____
Kidney Stones/Disease	☐ Yes ☐ No	☐ Yes ☐ No
How many episodes of stones: _____		Relationship to you: _____
What treatments were performed: _____		
Chronic Infection (TB)	☐ Yes ☐ No	☐ Yes ☐ No
Comment: _____		Relationship to you: _____
Seizures	☐ Yes ☐ No	☐ Yes ☐ No
Comment: _____		Relationship to you: _____
Hepatitis Liver Disease	☐ Yes ☐ No	☐ Yes ☐ No
Comment: _____		Relationship to you: _____
Have you ever been told you cannot donate blood?	☐ Yes ☐ No	
Comment: _____		
Cancer (Type)	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what type: _____		Relationship to you: _____
Treatment type: _____		
Years cancer free: _____		

Surgeries/Medical Procedures:

Date or Year	Surgery/Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Height: Feet _____ Inches_____Weight:_____ (lbs) Blood Type: ☐ A ☐ B ☐ AB ☐ O ☐ Unknown

Are you being pressured, coerced or offered compensation for donating? ☐ No ☐ Yes

Is your partner or family aware of your intent to donate a kidney? ☐ No ☐ Yes

Is the potential recipient aware of your intent to donate at this time? ☐ No ☐ Yes

Is your employer willing to give you time off after donating? ☐ No ☐ Yes

Review of Body Systems:

Check All That Apply

General:	☐ Fever	☐ Insomnia	☐ Stress	☐ Night Sweats	☐ Chills	☐ None
Head:	☐ Vision Problems	☐ Hearing Loss	☐ Earaches	☐ Nosebleeds	☐ Frequent Colds	☐ Frequent Sore Throat
	☐ Headaches	☐ Dizziness	☐ None			
Heart/Lungs:	☐ Chest Pain	☐ Wheezing	☐ Shortness of Breath	☐ Irregular Heartbeat	☐ None	
Gastrointestinal:	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ None	
Bleeding:	☐ Anemia	☐ Blood Clots	☐ Blood Transfusion	☐ None		
Musculoskeletal:	☐ Joint pain / Swelling	☐ Weakness	☐ Back Pain	☐ Numbness / Tingling	☐ None	
Psychological:	☐ Depression	☐ Anxiety	☐ Psychiatric Treatment	☐ Suicide Attempts	☐ None	
Endocrine:	☐ Excessive Thirst/Urination	☐ Heat/Cold Intolerance	☐ Thyroid Issues	☐ None		

Have you ever had the following tests: Colonoscopy: ☐ Yes ☐ No Year: _____ Mammogram: ☐ Yes ☐ No Year: _____

Pap Smear: ☐ Yes ☐ No Year: _____

These tests may be required depending on your age; please include results if you have them, or arrange to have them sent.

List All Medications, Vitamins, and Supplements:

_____

_____

_____

_____

_____

_____

_____

List Any Allergies: (Medicines and/or Foods) and Reactions:

_____

_____

_____

_____

_____

_____

_____

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Signature: _____ Date: _____