

Records

Living Donor Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 10/31/2010

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:*

- O A B AB A1 A1B A2 A2B

- Biological, blood related Parent
- Biological, blood related Child
- Biological, blood related Identical Twin

Donor Type: *

- Biological, blood related Full Sibling**
- Biological, blood related Half Sibling**
- 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, Living/Deceased Donation**
- Non-Biological, Unrelated: Domino**
- Non-Biological, Other Unrelated Directed Donation: Specify**

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

Black or African American

- African American
- African (Continental)
- West Indian
- 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

Asian

- Asian Indian/Indian Sub-Continent
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Asian: Other
- Asian: Not Specified/Unknown

Hispanic/Latino

- Mexican
- Puerto Rican (Mainland)
- Puerto Rican (Island)
- 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: *

- U.S. CITIZEN
- RESIDENT ALIEN
- NON-RESIDENT ALIEN, Year Entered US

Year of Entry into U.S.:

Highest Education Level: *

- NONE
- GRADE SCHOOL (0-8)
- HIGH SCHOOL (9-12)
- 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

If Yes:

- Unknown
- 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

HIV

YES NO

Test

Result

Positive

Negative

Screening:

Not Done

UNK/Cannot Disclose

Positive

Confirmation:

Negative

Not Done

UNK/Cannot Disclose

AIDS):

Was there clinical disease (ARC,

YES NO UNK

Positive

Antibody:

Negative

Not Done

UNK/Cannot Disclose

RNA:

Positive

Negative

- Not Done
- UNK/Cannot Disclose

CMV

- YES
- NO

Test

Result

CMV:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Was there clinical disease:

- YES
- NO
- UNK

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

Culture:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

HBV

- YES
- NO

Test

Result

Was there clinical disease: YES NO UNK

Positive

Liver Histology:

Negative

Not Done

UNK/Cannot Disclose

Positive

Core Antibody:

Negative

Not Done

UNK/Cannot Disclose

Positive

Surface Antigen:

Negative

Not Done

UNK/Cannot Disclose

Positive

HBV DNA:

Negative

Not Done

UNK/Cannot Disclose

Positive

HDV (Delta Virus):

Negative

Not Done

UNK/Cannot Disclose

HCV

YES NO

Test

Result

Was there clinical disease:

YES NO UNK

Positive

Liver Histology:

Negative

- Antibody:
- Not Done
 - UNK/Cannot Disclose
 - Positive
 - Negative
 - Not Done
 - UNK/Cannot Disclose
- RIBA:
- Positive
 - Negative
 - Not Done
 - UNK/Cannot Disclose
- HCV RNA:
- Positive
 - Negative
 - Not Done
 - UNK/Cannot Disclose

EBV

- YES NO

Test

Result

- Was there clinical disease:
- YES NO UNK
- IgG:
- Positive
 - Negative
 - Not Done
 - UNK/Cannot Disclose
- IgM:
- Positive
 - Negative
 - Not Done
 - UNK/Cannot Disclose
- EBV DNA:
- 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

0-10

11-20

21-30

If Yes, Check # pack years:

31-40

41-50

>50

Unknown pack years

0-2 months

3-12 months

13-24 months

Duration of Abstinence:

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

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:

Kidney Biopsy:* YES NO

Glomerulosclerosis: 0-5
 6-10
 11-15
 16-20
 20+
 Indeterminate

Pre-Donation Lung Clinical Information

	Before Bronchodilators		After Bronchodilators	
FVC % predicted:*	<input type="text"/>	ST= <input type="text"/>	<input type="text"/>	ST= <input type="text"/>

FEV1 % predicted:*	<input type="text"/>	ST= <input type="text"/>	<input type="text"/>	ST= <input type="text"/>
--------------------	----------------------	--------------------------	----------------------	--------------------------

FEF (25-75%) % predicted:*	<input type="text"/>	ST= <input type="text"/>	<input type="text"/>	ST= <input type="text"/>
----------------------------	----------------------	--------------------------	----------------------	--------------------------

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 (Peds)
- Left Lobe
- Right Lobe
- Domino Whole 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

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

Cerebrovascular Accident

Phrenic Nerve Injury

Brachial Plexus Injury

Breast Implant Rupture

Other Specify

RML

RUL

LUL

Lingular

Sacrifice of Second Lobe, Specify:

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 (In first 6 weeks post-donation)

Biliary Complications:*

YES NO UNK

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 UNK

If Yes, Specify:

Portal Vein

Hepatic Vein

Hepatic Artery

Pulmonary Embolus

Deep Vein Thrombosis

Other, Specify

Specify:

Other Complications Requiring Intervention:*

YES NO UNK

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 (In first 6 weeks post-donation)

Vascular Complications Requiring Intervention:*

YES NO UNK

If Yes, Specify:

Renal Vein

Renal Artery

- Aorta
- Vena Cava
- Pulmonary Embolus
- Deep Vein Thrombosis
- Other, specify

Specify:

Other Complications Requiring Intervention: *

- YES NO UNK

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 (In first 6 weeks post-donation)

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 (Within 6 weeks post-donation)

Most Recent Date of Tests:

Height:*

 ft in cm

ST=

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:

Did organ recovery and transplant occur at the same center: *

YES NO

Organ(s) Recovered

Recipient Name (Last, First)

Recipient SSN#

Donor Recovery Facility:

Donor Workup Facility:

UNOS View Only

Comments:

