Robert Wood Johnson University Hospital
LIVING DONOR REFERRAL FORM

LEGAL NAME____ SS#_________________________________

DOB_________________ AGE__________ SEX__________ RACE_______________RELIGION__________________

ADDRESS____

HEIGHT______________
WEIGHT______________

CITY_______________________ STATE_______________________ ZIP____________

HOME PHONE_______________________________CELL PHONE_______________________________

CAN WE LEAVE MESSAGES ON YOUR HOME PHONE MACHINE? ___________CELL PHONE? _________

EMAIL ADDRESS_______________________________CAN WE COMMUNICATE WITH YOU BY EMAIL? ________

WHAT IS THE BEST WAY TO REACH YOU? (home phone/cell phone/email) ______________

MARITAL STATUS: _____Single ___Married ___ Divorced ___Widowed ___Separated ____Other

CHILDREN (ages) ____

OCCUPATION: ____

ARE YOU TAKING ANY MEDICATIONS? _______WHAT ARE THEY? ___________________________________

____

MEDICAL/SURGICAL HISTORY ____

____

ALLERGIES____BLOOD TYPE (if known) ______________

Do any members of your family other than the recipient have diabetes or kidney disease? ____________________

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? **Please circle if YES**

Kidney Infection	Kidney Stones	Blood in the urine	Liver disease/ Hepatitis
Blood Disorder/Anemia	Cancer	Lung disease	Heart Problems
High Blood Pressure	Stroke	Drug/Alcohol Abuse	Psychiatric Problems
Diabetes/High blood sugar			

Who would you like to donate to? : ____

Please describe the nature of your relationship to this person (i.e. how do you know them and for how long?)

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If returning by mail send to: The Transplant Center at RWJUH, 10 Plum Street, 7th Floor, New Brunswick, NJ 08901

Edited 5/22/18 JA