SAINT BARNABAS MEDICAL CENTER
LIVING DONOR REFERRAL FORM

LEGAL NAME_____ SS#_____

DOB_____ AGE_____ SEX_____ RACE_____RELIGION_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HEIGHT_____

WEIGHT_____

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) _____

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			

Check Box if YES:

☐ I do not have a recipient and want to learn about non-directed kidney donation to someone in need of a kidney transplant

☐ I have a recipient that I want to donate to: Recipient's Name:_____

Your relationship with recipient (i.e. how do you know them and for how long)_____

If Recipient is a family member, do any family members, other than the recipient, have diabetes or kidney disease?

_____

☐ If my recipient receives a kidney transplant from another living donor, I may be interested in learning about non-directed living kidney donation.

If returning by mail send to: SBMC Living Donor Institute, 94 Old Short Hills Road, EW Suite 302, Livingston NJ 07039 or FAX to 973-322-2273

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