NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Center for Liver Disease & Transplantation
622 West 168th Street – 14th Flr, Ctr. Office
New York, NY 1003205-0914
Tel. 212-305-9381
Fax 212-342-5600

Dear Potential Donor,

It is a wonderful and courageous thing that you are considering doing. In order for us to ensure your safety and make sure you are fully informed of the risks and benefits of living donor transplantation and that you are healthy enough to give part of your liver to another person, we ask that you take a moment to complete the attached questionnaire.

After you fill out the questionnaire we will test your blood type to make sure it is compatible with the potential recipient and do a liver function blood test. It is important that you understand that at no point will you be contacted by our center to set up appointments. You must call for the results and to set up subsequent tests and procedures. We do this to ensure that you do not feel coerced by us in any way to donate. We expect that all our liver donors are donating of their own free will.

The donor evaluation is as follows:

1. Testing blood type compatibility
2. Consultation with Nurse Educator
3. Hepatology consultation appointment
4. Surgical consultation appointment
5. Laboratory tests. Blood and urine (we reserve the right to perform urine drug screens)
6. Chest X-Ray
7. EKG (Electrocardiogram)
8. Social Work evaluation
9. Psychiatric evaluation
10. MRI/MRA/MRCP of the liver

Potential donors with medical problems may require additional testing as determined by the Transplant Team.

If you have any questions, please feel free to contact our office.

Sincerely,

Jennica Kim
Living Donor Program Coordinator

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Living Donor Questionnaire

Name ______________________________ **Age** __________ **Sex** ________ **Race** ________

Donor Weight ________________ **Donor Height** ________________

Recipient Name ______________________ **Relationship to you** ______________________
Marital Status ______________________ **Number of Children** ______________________

Employment status (circle one)
Full Time / Part Time / Unemployed by choice / Unemployed unable to find work / Unemployed r/t illness / Retired

Occupation ______________________
Emergency Contact ______________________ **Telephone Number** ______________________
Relationship to you ______________________

Do you feel forced into a donor evaluation? YES NO

Reason for donating ____

Patient Medical History

Have you ever had the following (check "no or yes", leave blank if uncertain)

Measles	☐no ☐yes	Venereal Disease	☐no ☐yes	Blood or Plasma Transfusions	☐no ☐yes	Mitral Valve Prolapse	☐no ☐yes
Mumps	☐no ☐yes	Anemia	☐no ☐yes	Back Trouble	☐no ☐yes	Stroke	☐no ☐yes
Chicken Pox	☐no ☐yes	Bladder infections	☐no ☐yes	High or low Blood Pressure	☐no ☐yes	Hepatitis	☐no ☐yes
Whooping Cough	☐no ☐yes	Epilepsy	☐no ☐yes	Hemorrhoids	☐no ☐yes	Ulcer	☐no ☐yes
Scarlet Fever	☐no ☐yes	Migraine Headaches	☐no ☐yes	Asthma	☐no ☐yes	Kidney Disease	☐no ☐yes
Diphtheria	☐no ☐yes	Tuberculosis	☐no ☐yes	Hives or Eczema	☐no ☐yes	Thyroid Disease	☐no ☐yes
Smallpox	☐no ☐yes	Diabetes	☐no ☐yes	AIDS or HIV+	☐no ☐yes	Bleeding Tendency	☐no ☐yes
Pneumonia	☐no ☐yes	Cancer	☐no ☐yes	Infectious Mono	☐no ☐yes	Any Other Disease	☐no ☐yes
Rheumatic Fever	☐no ☐yes	Polio	☐no ☐yes	Bronchitis	☐no ☐yes	(Please list)	
Heart Disease	☐no ☐yes	Glaucoma	☐no ☐yes	Date of last X-Ray ______			
Arthritis	☐no ☐yes	Hernia	☐no ☐yes				

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________

Medications (Including over the counter medications)

____

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Patient Social History

Marital Status	☐Single	☐Married	☐Separated	☐Divorced	☐Widowed
Use of alcohol	☐Never	☐Rarely	☐Moderate	☐Daily	
Use of tobacco	☐Never	☐Previously quit ________	☐Started again__________	☐Current packs a day_____	
Use of drugs	☐Never	☐Type/Frequency			
Exposure at home or work to	☐Fumes	☐Dust	☐Solvents	☐Airborne Particles	☐noise

Family Medical History

	Age	*Diseases*	*If deceased, cause of death*
Father	______	______________________	______________________
Mother	______	______________________	______________________
Siblings	______	______________________	______________________
Siblings	______	______________________	______________________
Spouse	______	______________________	______________________
Children	______	______________________	______________________

Review of Systems: **Please indicate any personal history below**

General Health

Good General health lately	☐no ☐yes
Recent Weight Change	☐no ☐yes
Fever	☐no ☐yes
Fatigue	☐no ☐yes
Headache	☐no ☐yes

Eyes

Eye disease or injury	☐no ☐yes
Wear glasses/contact lenses	☐no ☐yes
Blurred or double vision	☐no ☐yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	☐no ☐yes
Earache or drainage	☐no ☐yes
Chronic Sinus Problems or Rhinitis	☐no ☐yes
Nose Bleeds	☐no ☐yes
Mouth Sores	☐no ☐yes
Bleeding gums	☐no ☐yes
Bad breath or bad taste	☐no ☐yes
Sore throat or voice change	☐no ☐yes
Swollen glands in neck	☐no ☐yes

Genital and Urinary

Frequent urination	☐no ☐yes
Burning or painful urination	☐no ☐yes
Blood in Urine	☐no ☐yes
Change in force of strain when urinating	☐no ☐yes
Incontinence or dribbling	☐no ☐yes
Kidney Stones	☐no ☐yes
Sexual difficulty	☐no ☐yes
Male-testicle pain	☐no ☐yes
Female pain with periods	☐no ☐yes
Female irregular periods	☐no ☐yes
Female-vaginal discharge	☐no ☐yes
Female- # of pregnancies	☐no ☐yes
Female- # of miscarriages	☐no ☐yes
Female- Date of last pap smear	☐no ☐yes

Musculoskeletal

Joint pain	☐no ☐yes
Joint stiffness or swelling	☐no ☐yes
Weakness of muscles or joints	☐no ☐yes
Muscle pain or cramps	☐no ☐yes

Psychiatric

Memory loss or confusion	☐no ☐yes
Nervousness	☐no ☐yes
Depression	☐no ☐yes
Insomnia	☐no ☐yes

Endocrine

Glandular or hormone problem	☐no ☐yes
Excessive thirst or urination	☐no ☐yes
Heat or cold intolerance	☐no ☐yes
Skin becoming drier	☐no ☐yes
Change in hat or glove size	☐no ☐yes

Hematologic/ lymphatic

Slow to heal after cuts	☐no ☐yes
Bleeding or bruising tendencies	☐no ☐yes
Anemia	☐no ☐yes
Phlebitis	☐no ☐yes
Past transfusion	☐no ☐yes
Enlarged glands	☐no ☐yes

Allergic/Imm-unologic

History of skin

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				reaction or other reaction to:	
Cardiovascular		Back pain	☐no ☐yes	Penicillin or other antibiotics	☐no ☐yes
Heart trouble	☐no ☐yes	Cold extremities	☐no ☐yes	Morphine, Demerol or other narcotics	☐no ☐yes
Chest pain or angina pecloris	☐no ☐yes	Difficulty in walking	☐no ☐yes	Novacaine or other anesthetics	☐no ☐yes
Palpitation	☐no ☐yes	**Skin / Breast**		Aspirin or other pain remedies	☐no ☐yes
Shortness of breath with walking or lying flat	☐no ☐yes	Rash or itching	☐no ☐yes	Tetanus antitoxin or other serums	☐no ☐yes
Swelling of feet, ankles or hands	☐no ☐yes	Change in skin color	☐no ☐yes	Iodine, methiolate or other antiseptics	☐no ☐yes
Respiratory		Change in hair or nails	☐no ☐yes	Other drugs/medications	☐no ☐yes
Chronic or frequent cough	☐no ☐yes	Varicose veins	☐no ☐yes		
Spitting up blood	☐no ☐yes	Breast pain	☐no ☐yes		
Shortness of breath	☐no ☐yes	Breast lump	☐no ☐yes		
Wheezing	☐no ☐yes	Breast discharge	☐no ☐yes		
Gastrointestinal		**Neurological**			
Loss of appetite	☐no ☐yes	Frequent recurring headaches	☐no ☐yes	Known food allergies	
Change in bowel movements	☐no ☐yes	Light headed or dizzy	☐no ☐yes		
Nausea or vomiting	☐no ☐yes	Convulsions or seizures	☐no ☐yes		
Frequent diarrhea	☐no ☐yes	Numbness or tingling sensations	☐no ☐yes		
Painful bowel movements or constipation	☐no ☐yes	Tremors	☐no ☐yes	Environmental Allergies	
Rectal bleeding or blood in stool	☐no ☐yes	Paralysis	☐no ☐yes		
Abdominal Pain	☐no ☐yes	Head injury	☐no ☐yes		

Over the past 12 months have you:

1) Had contact with a person with Hepatitis? Yes No Specify ______________________

2) Had unprotected sex? Yes No

3) Had sexual contact with persons suspected of having hepatitis or HIV? Yes No

4) Had any of the following:

Tattoos	Yes	No
Body Piercing	Yes	No
Acupuncture	Yes	No
Needle stick Injury	Yes	No

5) Injected in your skin for non-medical use? Yes No
6)Lived in a correctional facility or in jail? Yes No
7) Traveled outside the USA for business or pleasure? Yes No Location
8) Unexplained flu-like symptoms, cold, cough, swollen lymph nodes, night sweats, fever or significant weight loss? Yes No

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Intake Sheet

Medical Record Number: ____________________

Patient's Name: ______________________________ ______________________________
Last Name First Name

Street Address: ____ ______
Apt/Suite#

______________________________ ____________________ __________
City/Town State Zip Code

Gender: ______ **Race:** _________ **Ethnicity:** _______________

Social Security Number: _______-_____-_______ **Date of Birth:** _____/_____/_____

Home Phone: _______-_______-________ **Work Phone:** _______-_______-________

Pager Number: _______-_______-________ **Cell Phone:** _______-_______-________

E-Mail: ____

Mother's First Name: ____________________ **Father's First Name:** ____________________

In case your address or telephone number changes in the future please list three contacts we may call to get updated information for you:

Name:____________________________________ **Telephone #:**____________________

Name:____________________________________ **Telephone #:**____________________

Name:____________________________________ **Telephone #:**____________________

PCP: ____________________________ ____________________________ __________
First Name Last Name Title

Address: _________________________________ ______ **Telephone:** _____-_____-_____
Apt/Suite

________________________ _________________________ __________
City/Town State Apt/Suite

Primary Insurance:_______________________________ **ID#:** _________________________

May we contact the recipient if we need to get contact information for you? _______________

BDI

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY.
Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one.
Be sure to read all the statements in each group before making your choice.

Client Name ______________________________ **Date:** ____________

Sadness
0. I do not feel sad.
1. I feel sad much of the time.
2. I am sad all the time.
3. I am so sad or unhappy that I can't stand it.

Pessimism
0. I am not discouraged about my future.
1. I feel more discouraged about my future than I used to be.
2. I do not expect things to work out for me.
3. I feel my future is hopeless and will only get worse.

Past Failure
0. I do not feel like a failure.
1. I have failed more than I should have.
2. As I look back I see a lot of failures.
3. I feel I am a total failure as a person.

Loss of Pleasure
0. I get as much pleasure as I ever did from the things I enjoy.
1. I don't enjoy things as much as I used to.
2. I get very little pleasure from the things I used to enjoy.
3. I can't get any pleasure from the things I used to enjoy.

Guilty Feelings
1. I don't feel particularly guilty.
2. I feel guilty over many things I have done or should have done.
3. I feel guilty most of the time.
4. I feel guilty all the time.

Punishment Feelings
1. I don't feel I am being punished.
2. I feel I may be punished.
3. I expect to be punished.
4. I feel I am being punished.

Self-Dislike
0. I feel the same about myself as ever.
1. I have lost confidence in myself.
2. I am disappointed in myself.
3. I dislike myself.

Self-Criticalness
0. I don't criticize or blame myself more than usual.
1. I am more critical of myself than I used to be.
2. I criticize myself for all of my faults.
3. I blame myself for everything bad than happens.

Suicidal Thoughts or Wishes
0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

Crying
0. I don't cry anymore than I used to.
1. I cry more than I used to.
2. I cry over every little thing.
3. I feel like crying, but I can't.

Agitation
0. I am no more restless or wound up than usual.
1. I feel more restless or wound up than usual.
2. I am so restless or agitated that it's hard to stay still.
3. I am so restless or agitated that I have to keep moving or doing something.

Loss of Interest
0. I have not lost interest in other people or activities.
1. I am less interested in other people or things than before.
2. I have lost most of my interest in other people or things.
3. It's hard to get interested in anything.

Indecisiveness
0. I make decisions about as well as ever.
1. I find it is more difficult to make decisions than usual.
2. I have much greater difficulty in making decisions than I used to.
3. I have trouble making any decisions.

Worthlessness
0. I do not feel I am worthless.
1. I don't consider myself as worthwhile and useful as I used to.
2. I feel more worthless as compare to other people.
3. I feel utterly worthless.

Loss of Energy
0. I have as much energy as ever.
1. I have less energy than I used to have.
2. I don't have enough energy to do very much.
3. I don't have enough energy to do anything.

Changes in Sleeping Pattern
0. I have not experienced any change in my sleeping pattern.
1. I sleep somewhat less than usual. –or– I sleep somewhat more than usual.
2. I sleep a lot less than usual. –or– I sleep a lot more than usual.
3. I sleep most of the day. –or– I wake up 1-2 hours early and can't get back to sleep.

Irritability

0. I am no more irritable than usual.
1. I am more irritable than usual.
2. I am much more irritable than usual.
3. I am irritable all the time.

Changes in Appetite

0. I have not experienced any change in my appetite.
1. My appetite is somewhat less than usual. –or– My appetite is somewhat greater than usual.
2. My appetite is much less than usual. –or– 17 My appetite is much greater than usual.
3. I have no appetite at all. –or– I crave food all the time.

Concentration Difficulty

0. I can concentrate as well as ever.
1. I can't concentrate as well as usual.
2. It's hard to keep my mind on anything for very long.
3. I find I can't concentrate on anything.

Tiredness or Fatigue

0. I am no more tired or fatigued than usual.
1. I get more tired or fatigued more easily than usual.
2. I am too tired or fatigued to do a lot of the things I used to do.
3. I am too tired or fatigued to do most of the things I used to do.

Loss of Interest in Sex

0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I am much less interested in sex now.
3. I have lost interest in sex completely

Beck Anxiety Scale

Date:__________

		Not at all	Mildly (It did not bother me much.)	Moderately (It was very unpleasant but I could stand it..)	Severely (I could barely stand it.)
1	Difficulty breathing	0	1	2	3
2	Difficulty sleeping at night	0	1	2	3
3	Dizzy or lightheaded	0	1	2	3
4	Face flushed	0	1	2	3
5	Faint	0	1	2	3
6	Fear of dying	0	1	2	3
7	Fear of losing control	0	1	2	3
8	Fear of the worst happening	0	1	2	3
9	Feeling hot	0	1	2	3
10	Feelings of choking	0	1	2	3
11	Hands trembling	0	1	2	3
12	Heart pounding or racing	0	1	2	3
13	Indigestion or discomfort in abdomen	0	1	2	3
14	Nervous	0	1	2	3
15	Numbness or tingling	0	1	2	3
16	On edge	0	1	2	3
17	Racing thoughts	0	1	2	3
18	Shaky	0	1	2	3
19	Sweating (not due to heat)	0	1	2	3
20	Terrified	0	1	2	3
21	Unable to relax	0	1	2	3
22	Unsteady	0	1	2	3
23	Wobbliness in legs	0	1	2	3

Total Score:

0-16 = mild anxiety
17–30 = moderate anxiety
31 and above = severe anxiety

Living Liver Donor Mentoring Program

The goal of the living liver donor mentoring program is to give potential donors the option to meet with or have a telephone conversation with a person who has already gone through the donor experience at the Center for Liver Disease and Transplantation. You will be given this opportunity after your evaluation has been completed and only if you have been cleared as a donor.

Meeting with a donor mentor will help you to:

- Identify from a donor's point of view the donation process
- Better understand possible risks from someone who has been through the process
- Have the ability to ask donors questions without feeling pressured
- Better understand what to expect during the post operative course.
- Understand that everyone's donation experience is different
- Have an advocate outside the medical profession to call, ask questions when concerns come up.

If you have any questions or concerns about the living liver donor mentoring program please call 212-305-9381.

Would you like the opportunity to meet with a living liver donor mentor?
Please sign one selection.

YES ______________________________ ____________
SIGNATURE *DATE*

Please circle you choice of contact:

By Telephone **In Person** **By E-mail**

- OR –

NO ______________________________ ____________
SIGNATURE *DATE*