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
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 Measles □no □yes
Mumps □no □yes Mumps □no □yes
Chicken Pox □no □yes Chicken Pox □no □yes
Whooping Cough □no □yes Whooping Cough □no □yes
Scarlet Fever □no □yes Scarlet Fever □no □yes
Diphtheria □no □yes Diphtheria □no □yes
Smallpox □no □yes Smallpox □no □yes
Pneumonia □no □yes Pneumonia □no □yes
Rheumatic Fever □no □yes Rheumatic Fever □no □yes
Heart Disease □no □yes Heart Disease □no □yes
Arthritis □no □yes Arthritis □no □yes

Venereal Disease □no □yes Venereal Disease □no □yes
Anemia □no □yes Anemia □no □yes
Bladder infections □no □yes Bladder infections □no □yes
Epilepsy □no □yes Epilepsy □no □yes
Migrane Headaches □no □yes Migrane Headaches □no □yes
Tuberculosis □no □yes Tuberculosis □no □yes
Diabetes □no □yes Diabetes □no □yes
Cancer □no □yes Cancer □no □yes
Polio □no □yes Polio □no □yes
Glaucoma □no □yes Glaucoma □no □yes
Hernia □no □yes Hernia □no □yes

Blood or Plasma Transfusions □no □yes Blood or Plasma Transfusions □no □yes
Back Trouble □no □yes Back Trouble □no □yes
High or low Blood Pressure □no □yes High or low Blood Pressure □no □yes
Hemorrhoids □no □yes Hemorrhoids □no □yes
Asthma □no □yes Asthma □no □yes
Hives or Eczema □no □yes Hives or Eczema □no □yes
AIDS or HIV+ □no □yes AIDS or HIV+ □no □yes
Infectious Mono □no □yes Infectious Mono □no □yes
Bronchitis □no □yes Bronchitis □no □yes

Miral Valve Prolapse □no □yes Miral Valve Prolapse □no □yes
Stroke □no □yes Stroke □no □yes
Hepatitis □no □yes Hepatitis □no □yes
Ulcer □no □yes Ulcer □no □yes
Kidney Disease □no □yes Kidney Disease □no □yes
Thyroid Disease □no □yes Thyroid Disease □no □yes
Bleeding Tendency □no □yes Bleeding Tendency □no □yes
Any Other Disease □no □yes Any Other Disease □no □yes

(Please list)

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

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Medications (Including over the counter medications)

__________________________________________________________________________
**Patient Social History**

- **Marital Status**
  - Single
  - Married
  - Separated
  - Divorced
  - Widowed

- **Use of alcohol**
  - Never
  - Rarely
  - Moderate
  - Daily
  - Previously quit
  - Started again
  - Previously quit
  - Moderate

- **Use of tobacco**
  - Never
  - Previously quit
  - Started again
  - Previously quit
  - Previously quit
  - Type/Frequency

- **Use of drugs**
  - Fumes
  - Dust
  - Solvents
  - Airborne Particles

- **Exposure at home or work to**
  - Fumes
  - Dust
  - Solvents
  - Airborne Particles

**Family Medical History**

<table>
<thead>
<tr>
<th>Age</th>
<th>Diseases</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
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<tr>
<td>Siblings</td>
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<tr>
<td>Siblings</td>
<td></td>
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<tr>
<td>Spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- **General Health**
  - Good General health lately
  - Recent Weight Change
  - Fever
  - Fatigue
  - Headache
  - Eyes

- **Genital and Urinary**
  - Frequent urination
  - Burning or painful urination
  - Blood in Urine
  - Change in force of strain when urinating
  - Incontinence or dribbling
  - Kidney Stones

- **Psychiatric**
  - Memory loss
  - Nervousness
  - Depression
  - Insomnia

- **Endocrine**
  - Glandular or hormone problem
  - Excessive thirst or urination
  - Heat or cold intolerance
  - Skin becoming drier
  - Change in hat or glove size

- **Fars/Nose/Mouth/Throat**
  - Female-testicle pain
  - Male-testicle pain
  - Female pain with periods
  - Female irregular periods
  - Female-vaginal discharge
  - Female- # of pregnancies
  - Female- # of miscarriages

- **Musculoskeletal**
  - Female- Date of last pap smear
  - Joint pain
  - Joint stiffness or swelling
  - Weakness of muscles or joints
  - Muscle pain or cramps

- **Hematologic/lymphatic**
  - Bleeding or bruising tendencies
  - Anemia

- **Nose Bleeds**
  - Pneumonias
  - Phlebitis

- **Mouth Sores**
  - Bleeding gums
  - Enlarged glands

- **Bad breath or bad taste**
  - Joint stiffness or swelling

- **Sore throat or voice change**
  - Weakness of muscles or joints

- **Swollen glands in neck**
  - History of skin
### Cardiovascular

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain or angina pectoris</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath with walking or lying flat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swelling of feet, ankles or hands</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Respiratory

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Change in hair or nails</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic or frequent cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spitting up blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in bowel movements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful bowel movements or constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal bleeding or blood in stool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicose veins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast lump</td>
<td></td>
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</tr>
<tr>
<td>Breast discharge</td>
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<tr>
<td>Neurological</td>
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<tr>
<td>Varicose veins</td>
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<tr>
<td>Breast pain</td>
<td></td>
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</tr>
<tr>
<td>Breast lump</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other

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
- Body Piercing
- Acupuncture
- Needle stick Injury

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
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? ___________.


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 compared 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 — 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: _________

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

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 your choice of contact:

By Telephone  In Person  By E-mail

- OR -

NO

SIGNATURE __________________________ DATE __________________________