

The Johns Hopkins Comprehensive Transplant Center Potential Donor Candidate Profile

All information obtained in this profile will be confidential.

Name: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (home) _____ (work) _____

Other Contact Numbers: _____ (or) _____

E-mail address: _____

Mother's Maiden Name: _____ Father's Last Name: _____

Who are you interested in donating to? _____

What is your relationship to this person? _____

MEDICAL INFORMATION

Name of family physician: _____

Telephone Number: _____

Are you being treated by a physician for any of the following problems? Circle if yes.

High blood sugar High Blood Pressure Heart Problems Cancer

Liver problems Lung problems

If yes, please explain: _____

Please list any operations or other health problems that you have had: (include approximate date)

Did you experience any medical complications associated with any of the operations listed above? _____

Have you ever had a transfusion? Yes _____ No _____ If yes, when and what were the circumstances? _____

Height: _____ Weight: _____ Blood Type: _____
Allergies: _____

List all medications that you are currently taking:

EMPLOYMENT & FAMILY INFORMATION

Employment status: Full time _____ Part time _____
What type of job? _____

Are you able to take 4 to 6 weeks off of work? Yes _____ No _____

Marital Status: Single _____ Married _____

Do you have any children? Yes _____ No _____ Age (s) _____

Are you a caregiver for any other dependent person? Yes _____ No _____

Are you the only wage earner in your family? Yes _____ No _____

Do you live with your family? Yes _____ No _____

Have you discussed your decision with your family? Yes _____ No _____

Have they agreed with your decision? Yes _____ No _____

Are you under any pressure to donate? Yes _____ No _____

Why do you wish to donate? _____

TOBACCO & ALCOHOL INFORMATION

Do you currently use tobacco of any kind? Yes _____ No _____

If yes, do you smoke or chew? _____

How much do you use per day? _____

How long have you been using tobacco? _____

Did you use tobacco in the past? Yes _____ No _____

If yes, did you smoke or chew? _____

How much did you use per day? _____

How long did you use tobacco? _____

When was the last time you used tobacco? _____

Do you drink? Yes _____ No _____

Beer _____ Wine _____ Mixed drinks _____ Other _____

How often do you drink? _____

Please describe the amount of alcohol that you drink: _____

Did you used to drink alcohol? Yes _____ No _____

Describe the amount and type of alcohol that you used to drink: _____

When did you last drink any alcohol? _____

DRUG INFORMATION

Have you experimented with marijuana or any other illegal substance? Yes _____ No _____

Have you ever experimented with intravenous drugs? Yes _____ No _____

If yes, please explain: _____

Have you ever been in a treatment program for substance abuse? Yes _____ No _____

If yes, please explain: _____

OTHER INFORMATION

Have you ever been seen by a mental health counselor or psychiatrist? Yes _____ No _____

Have you been out of the country in the past 12 months? Yes _____ No _____

Have you received any tattoos or body piercing in the past 12 months? Yes _____ No _____

Is there any other information that you think we should be aware of? _____

If you have any questions, please call the Liver Transplant Office at 410-614-2989

Please return this form to:

Liver Transplant Office

600 N. Wolfe Street

Blalock 242

Baltimore, MD 21287

Fax: 410-614-8741