Donor Outreach for Veterans, Corp. (DOVE)
Phone: 646-245-2894
Email: Donor@DOVETransplant.org
Website: www.DOVETransplant.org

DONOR REGISTRATION FORM

ELIGIBLE DONORS MUST BE BETWEEN THE AGES OF 18-70 AND IN GENERAL GOOD HEALTH.
DOVE, Corp. keeps all information confidential. Please sign the medical release form so that communications can be shared between hospital providers and DOVE, Corp. Thank you.

Please answer all questions, printing neatly and legibly using BLOCK LETTERS

DONOR				
Last Name:	First Name:	Middle Name:		
Height:	Weight:	Date of Birth:	Age:	Gender: ☐ M ☐ F
Home Phone: (Enter Numbers Only)	Cell Phone: (Enter Numbers Only)	Work Phone: (Enter Numbers Only)		
Street Address:	City:	State:	ZIP Code:	Country:
Email:	Employer:	Health Insurance:		
Prescribed and Over-the-Counter Medications:		Blood Type: ☐ A ☐ B ☐ AB ☐ O ☐ Don't Know		
List all Hospitalizations and Surgeries within the Past 10 years:				
Marital Status:	Partner Name:	Partner Contact:		

GENERAL HEALTH

1	Are you currently taking prescription or nonprescription drugs?	☐ Yes	☐ No
2	Do you have a history of hypertension (high blood pressure)?	☐ Yes	☐ No
3	Have you ever had any episodes of chest pain or shortness of breath?	☐ Yes	☐ No
4	Do you or any family members have a history of kidney stones?	☐ Yes	☐ No
5	Do you or any family members have a history of diabetes?	☐ Yes	☐ No
6	Do you have any history of kidney disease or frequent infections of bladder or kidney?	☐ Yes	☐ No
7	Have you ever had a heart attack?	☐ Yes	☐ No
8	Have you ever had a stroke?	☐ Yes	☐ No

9	Have you ever had a blood transfusion?	☐ Yes	☐ No
10	Have you ever been treated for depression or a mental health problem?	☐ Yes	☐ No
11	Do you smoke cigarettes or vape?	☐ Yes	☐ No
12	Do you smoke marijuana?	☐ Yes	☐ No
13	Have you ever been referred for treatment for a substance abuse problem?	☐ Yes	☐ No
14	Have you had any major illnesses or surgical procedures in the past?	☐ Yes	☐ No
15	Have you been treated for any chronic medical condition such as HIV or Hepatitis	☐ Yes	☐ No
16	Are you allergic to any foods or medications?	☐ Yes	☐ No
17	Have you ever suffered from any type of liver disease/hepatitis?	☐ Yes	☐ No
18	Do you have any history of digestive or intestinal problems?	☐ Yes	☐ No
19	Have you experienced any recent periods of explained or unexplained weight loss?	☐ Yes	☐ No
20	Do you have any history of asthma, emphysema, or any other lung disease?	☐ Yes	☐ No
21	Were you ever refused as a blood donor or told not to donate?	☐ Yes	☐ No
22	Have you received the COVID-19 vaccine?	☐ Yes	☐ No

Q#	Explanations to all "yes" responses (including underlying conditions and medication that apply):

Why do you want to donate? _____

Is there a particular person you would like to donate your kidney to? If yes, please list: _____

If applicable, where did you see the advertisement for this drive? _____

Do you feel pressure in pursuing kidney donation? ☐ Yes ☐ No Does your partner/family know that you're pursuing donation? ☐ Yes ☐ No

Will you be able to take two weeks off after surgery and 2-3 random days of testing? ☐ Yes ☐ No

Female Donors Only:

Number of Pregnancies: _____ Number of Births: _____ Date of Last Pregnancy: _____

Are you pregnant or trying to get pregnant? Were you ever diagnosed with: Gestational Diabetes? Hypertension with Pregnancy?

The information presented by DOVE, Corp is provided as a courtesy. It is provided for informational purposes only and is not provided as a professional service or as medical advice for specific patients or donors. It is not a substitute for professional medical care. If a potential donor has, or suspects that he/she may have a health problem, the potential donor should consult his/her health care provider to obtain medical information and recommendations. DOVE, Corp expressly disclaims any representation or warranty express or implied concerning the accuracy, completeness or fitness for a particular purpose of the information. Persons accessing this information assume full responsibility for the use of the information and understand and agree that DOVE, Corp is not responsible or liable for any claim, loss or damage arising from the use of the information.

The medical information is provided as an information resource only and is not to be used or relied on for any diagnostic or treatment purposes. This information is not intended to be patient education, does not create any patient-physician relationship, and should not be used as a substitute for professional diagnosis and treatment. Please consult your health care provider before making any healthcare decisions or for guidance about a specific medical condition. DOVE, Corp expressly disclaims responsibility, and shall have no liability, for any damages, loss, injury, or liability whatsoever suffered as a result of your reliance on the information received from DOVE, Corp. DOVE, Corp does not endorse specifically any test, treatment, or procedure that a potential donor may be given.

Signature: _____ Date: _____

Medical Records Release Form

I hereby authorize full disclosure (including paper, oral and electronic interchange) to DOVE, Corp. and all its employees, of all my medical records. This includes specific information, such as, records and other information, including and not limited to treatment, hospitalization and outpatient care.

Printed Name: _____

Signature: _____ Date: : _____

For Official Use Only

Intake:	BMI:	Dr:		Nurse:
BP:		Transplant Center:		Approved:
Heart Rate:		Blood Was Drawn:	By:	Interviewed By: