

Medical Information

If it is more convenient, you may e-mail the requested information in a PDF (or other) format to cli-labs@charter.net.

Potential Donor Name _____ Date of Birth _____

Donor medical histories are a very important part of the donation process. To aid us in obtaining a complete medical record, please fill in the information to the best of your knowledge and check all that apply below:

Gender _____ Height _____ Weight _____

Has the donor had any of the following diseases or conditions?

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Active MRSA (Methicillian Resistant Staphylococcus Aureus | <input type="checkbox"/> Active VRE (Vancomycin Resistant Enterococci) | | |
| <input type="checkbox"/> Dementia (____ Years) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> C. diff (Clostridium difficile) |
| <input type="checkbox"/> TB (Tuberculosis) | <input type="checkbox"/> Decubitus Ulcers | <input type="checkbox"/> Jaundice | |
| <input type="checkbox"/> Cancer _____ Treatment(s)/ Year(s) _____ | | | |
| <input type="checkbox"/> Other Contagious Disease(s) _____ | | | |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Skeletal Anomalies _____ | | |
| <input type="checkbox"/> Substance Abuse- List Substance(s) _____ | | | |

Has the donor had any of the following surgeries?

- | | |
|--|---|
| <input type="checkbox"/> Heart Surgery- Year _____ | <input type="checkbox"/> Spine Surgery- Year _____ |
| <input type="checkbox"/> Colostomy- Year _____ | <input type="checkbox"/> Gall Bladder Removed- Year _____ |
| <input type="checkbox"/> Appendix Removed- Year _____ | <input type="checkbox"/> Tonsils Removed- Year _____ |
| <input type="checkbox"/> Joint Replacement Surgery- Joint(s) / Year(s) _____ | |
| <input type="checkbox"/> Amputation(s) _____ | |
| <input type="checkbox"/> Other Surgical History _____ | |

Female Donors:

- | | |
|--|--|
| <input type="checkbox"/> Hysterectomy Year _____ | <input type="checkbox"/> Cesarean Section- Year(s) _____ |
| <input type="checkbox"/> Number of Children Given Birth To _____ | |

Please provide a list of medications:

Please list primary care providers and institutions from which the donor has received medical care:

Additionally, we request that you attach a copy of any medical records in your possession pertaining to the past physical condition of this individual. Thank. If you any questions, please call.

For more information in the future, whom can we contact?

Name _____ Phone/Fax _____