

PKD Foundation Tissue Donation Form

Date of Initial Call/Email:

Patient Information:

Date of Birth: _____
Gender: () Male () Female () Other _____
Diagnosis: () ADPKD () ARPKD () PKD - Unknown Type
Blood Work: (if known)
Creatinine level _____
BUN level _____
Dialysis: () Yes - for how long? _____ () No
Prior transplant: () Yes – when? _____ () No
Number of kidneys being removed () 1 () 2
Notes:

Date of Surgery:

Surgeon:

Name:
Hospital:
Hospital City/State:
Phone Number:

➤ *Have you advised the surgeon of his/her decision to donate tissue?*

If the answer is no, please advise donor to do so as soon as possible.

Nurse/Coordinator:

Name:
Phone Number:
Fax Number if known:
Email address:

Pathologist: (If known)

Name: _____
Phone #: _____
Fax #: _____

Notes, comments, other important information:

How did you learn about the ability to donate discarded tissue?