PKD FOUNDATION
Polycystic kidney disease

PKD Foundation Tissue Donation Form

Date of Initial Call/Email:

Patient Information:

Age: _____
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?