PKD FOUNDATION
Polycystic Kidney Disease

# 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?**