WHAT CAN YOU DO *NOW* TO GET READY FOR KIDNEY DONATION?

- Continue to educate yourself about donation. Websites we like include www.legacytransplant.org, www.exploretransplant.org, and www.kidney.org

- Do you want to know your blood type? Donate blood through the American Red Cross to find out.

- Think ahead about possible care partner(s) who will help you through the recovery period after donation surgery. This is especially important if you are donating to your spouse/significant other/family member. You will both need care partners.

- If you have health insurance, get your routine health screenings done: colonoscopy for everyone over 45, mammogram for women over 40, and pap for women.

- If employed, get to know your vacation, sick leave, and short-term disability policies. Donors are usually off work 3-6 weeks.

- Prepare for any expenses. The recipient's insurance will cover the costs of your donor evaluation, surgery, and time in the hospital. What is not covered is travel to Portland, daily expenses while in Portland, and any lost wages.

- Take care of yourself:
  - Eat a healthy diet
  - Stay at or get to a healthy weight for you
  - Be active – physically, mentally, and socially

LEGACY HEALTH

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.
Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? ☐Yes ☐No
Patient's Mailing Address		

Healthcare Provider to **Release** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

Person or Agency to **Receive** Information:

Name	Legacy Transplant Services - Living Donation	
Address	1130 NW 22nd Ave Suite 400	
City: Portland	State: OR	Zip: 97210
Phone: 503-413-6990	Fax: 503-415-8402	

Purpose of release: Living kidney donor evaluation

If such information exists, I authorize the disclosure of ☐ the entire medical record **or** ☐the following specific documents, dates of service, and/or information about the following injury/illness/disease:

● past five years

The following items **must be initialed** to be released:

_____ HIV-positive test results and HIV diagnosis
_____ Mental health information and/or records (Oregon only)
_____ Genetic testing information and/or records (Oregon only)
_____ Other sexually transmitted diseases (Washington only)
_____ Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire on the earlier of 1 year from the date of signing or on _____.

I am requesting the following records in electronic format:

❑Discharge Instructions ❑Available Electronic Medical Record

_____ _____
Signature of Patient or Patient's Legal Representative — Date

_____ _____
Print Name (If other than the patient, proof of authority is required.) — Relationship to Patient

(8/11)
A copy of this signed form will be provided to the patient or personal representative.

306835

Legacy Living Kidney Donor Team
Legacy Transplant Services
Legacy Good Samaritan Medical Center
1130 NW 22nd Avenue, Suite 400
Portland, Oregon 97210
PHONE 503-413-6990
FAX 503-415-8402

Blood Pressure Screening Record for_____

Date of birth _____

Blood Pressure readings should be done with a blood pressure cuff that fits your arm well. A blood pressure cuff that is too large or too small will give an inaccurate result. This can be done on an automatic cuff at home, local pharmacy, drug store or possibly the grocery store. It can also be done at a medical office or a local fire station.

Please take the blood pressure readings at different times of the day over a couple of days. (ie: morning, afternoon, evening)

3 Blood Pressures

Location of the test: _____ (ie: at a store, pharmacy, medical clinic, fire station, home)

Please note the type of cuff:_____ (ie: upper arm automatic cuff, wrist cuff, or manual cuff)

Example:
Jan. 2nd 11:00 am left sitting BP= 136 / 78 Pulse (heart-rate) 76

Date & time	Circle			
_____	left or right:	sitting	____/_____	Pulse _____
_____	left or right:	sitting	____/_____	Pulse _____
_____	left or right:	sitting	____/_____	Pulse _____