

RECIPIENT DETAILS	
SURNAME (Please print) *	DOB *
GIVEN NAMES *	FEMALE MALE
BLOOD GROUP Attach Blood group Result or upload into OrganMatch	ETHNICITY/COUNTRY OF ORIGIN
CLINICAL UNIT *	TRANSPLANT UNIT *
HOSPITAL REFERENCE NUMBER (MRN)	HOSPITAL REFERENCE NUMBER (MRN)
TREATING CONSULTANT	TREATING CONSULTANT

ORGAN
<input type="checkbox"/> LIVER <input type="checkbox"/> INTESTINE <input type="checkbox"/> PANCREAS <input type="checkbox"/> PANCREAS ISLETS <input type="checkbox"/> KIDNEY/PANCREAS (Combined)
<input type="checkbox"/> OTHER (Please specify)
PRIMARY DIAGNOSIS

TRANSFUSION HISTORY		
PREVIOUS TRANSFUSIONS	YES	NO UNKNOWN
NUMBER OF TRANSFUSIONS	DATE OF LAST TRANSFUSION	

PREGNANCY HISTORY (if applicable)	
NUMBER OF PREGNANCIES	DATE OF LAST PREGNANCY (Year)

TRANSPLANT HISTORY	
NUMBER OF TRANSPLANTS	DATE OF LAST TRANSPLANT FAILURE
TRANSPLANT LOCATION:	<input type="checkbox"/> AUSTRALIA <input type="checkbox"/> OVERSEAS (Please specify country)
CAUSE OF GRAFT FAILURE FOR LAST TRANSPLANT	

DIALYSIS HISTORY (if applicable)	
DIALYSIS CENTRE	DIALYSIS TYPE
DATE OF DIALYSIS	for: <input type="checkbox"/> FIRST DIALYSIS or <input type="checkbox"/> DIALYSIS RECOMMENCEMENT AFTER TRANSPLANT

TRANSPLANT UNIT SIGN-OFF	
FULL NAME (Please print)	POSITION
SIGNATURE	DATE

REGISTRATION AND ENROLMENT OF PATIENTS THROUGH THE TRANSPLANTATION PORTAL IS PREFERRED