

TRANSPLANT RECIPIENT	
SURNAME (Please print) *	DOB * <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
GIVEN NAMES *	
CLINICAL UNIT *	TRANSPLANT UNIT *
HOSPITAL REFERENCE NUMBER (MRN)	HOSPITAL REFERENCE NUMBER (MRN)
TREATING CONSULTANT	TREATING CONSULTANT

INCREASED VIRAL RISK (IVR)	Please attach a copy of specific consent for IVR or upload to OM	
WILLING TO ACCEPT INCREASED VIRAL RISK DONOR?	<input type="checkbox"/> YES, ENROL	<input type="checkbox"/> NO, REMOVE ENROLMENT

HEPATITIS C POSITIVE	Please attach a copy of specific consent or upload to OM	
WILLING TO ACCEPT HEPATITIS C POSITIVE DONOR?	<input type="checkbox"/> YES, ENROL	<input type="checkbox"/> NO, REMOVE ENROLMENT
<i>Enrolments will expire in 12 months. A notification will be sent one month prior to expiry, to allow for reenrolment if applicable.</i>		

ABO INCOMPATIBLE (ABOi)	Please attach a copy of the pathology report or upload to OM	
WILLING TO ACCEPT ABOi DONOR?	<input type="checkbox"/> YES, ENROL for incompatible group:	<input type="checkbox"/> NO, REMOVE ENROLMENT
	<input type="checkbox"/> AB	

TUMOUR RESECTED KIDNEY	Please attach a copy of specific consent or upload to OM	
WILLING TO ACCEPT TUMOUR RESECTED DONOR KIDNEY ?	<input type="checkbox"/> YES	<input type="checkbox"/> NO, REMOVE ENROLMENT

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

REGISTRATION AND ENROLMENT OF PATIENTS THROUGH THE TRANSPLANTATION PORTAL IS PREFERRED