



## Potential Living Donor Follow-up Form

**Public Burden Statement:** The purpose of this data collection is to track long-term health outcomes for living organ donors. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0906-0034, and it is valid until XX/XX/XXXX. This information collection is voluntary. Data will be kept private to the extent allowed by law. Information proposed to be collected is considered to be protected health information. SRTR is a public health authority under the HIPAA Privacy Rule (45 CFR 164.512(b)). Also refer to the HRSA System of Record Notice 09-15-0055, <https://www.federalregister.gov/documents/2022/08/01/2022-16344/privacy-act-of-1974-system-of-records>. Public reporting burden for this collection of information is estimated to average .29 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857, or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).

**Thank you for the actions you took to be evaluated as a living donor. Regardless of whether or not you donated, we want to learn more about the effects that considering donation or becoming a living donor had on your life. We invite you to be part of a registry to examine the effects over time of being evaluated or donating.**

### Year One Follow Up

1. **Would you be willing to help us by answering a series of short questions going forward?**

Yes

No

Other: **1a. Please specify:** \_\_\_\_\_

2. **Confirm address and phone numbers and preferred method of contact:**

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3. **Would you say your health in general is:**

Excellent

Very good

Good

Fair

Poor

Declined to respond or don't know

4. **Compared with before evaluation for donation, would you say your health is:**

Much better

Somewhat better

Not different

Somewhat worse

Much worse

Declined to respond or don't know



5. Do you have an impairment or health problem that limits your ability to walk or run?

- Yes
- No
- Declined to respond or don't know

6. Are you limited in the kind or amount of work you can do because of a physical, mental, or emotional problem?

- Yes
- No
- Declined to respond or don't know

7. In general, how you would rate your mental health, including your mood or ability to think?

- Excellent
- Very good
- Good
- Fair
- Poor
- Declined to respond or don't know

8. In general, how would you rate your satisfaction with your social activities and relationships?

- Excellent
- Very good
- Good
- Fair
- Poor
- Declined to respond or don't know

9. Please rate how much of a financial burden volunteering to donate has been to you and your family.

(check one box)

No financial burden	E extreme financial burden
▼	▼
0 <input type="checkbox"/>	10 <input type="checkbox"/>
1 <input type="checkbox"/>	9 <input type="checkbox"/>
2 <input type="checkbox"/>	8 <input type="checkbox"/>
3 <input type="checkbox"/>	7 <input type="checkbox"/>
4 <input type="checkbox"/>	6 <input type="checkbox"/>
5 <input type="checkbox"/>	5 <input type="checkbox"/>
6 <input type="checkbox"/>	4 <input type="checkbox"/>
7 <input type="checkbox"/>	3 <input type="checkbox"/>
8 <input type="checkbox"/>	2 <input type="checkbox"/>
9 <input type="checkbox"/>	1 <input type="checkbox"/>
10 <input type="checkbox"/>	0 <input type="checkbox"/>

10. If you could do it over again, would you?

- Definitely yes
- Probably yes
- Not sure
- Probably not
- Definitely not
- Declined to respond or don't know



SCIENTIFIC REGISTRY OF  
TRANSPLANT RECIPIENTS



LIVING DONOR  
COLLECTIVE

OMB Control No. 0906-0034  
Expiration Date XX/XX/XXXX