Donor Information Checklist Form

Donor Initials: _____Age: _____Yrs. Sex: M / F Race:_____ DOB:_____, Weight: _____pounds, height: _____
Surgeon Name:_____ Clinic Name and address:_____
Liposurgery Date: _____Time: _____Total Lipoaspirate Collected (mL):_____
Body part lipoaspirate collected: _____

Screening Criteria	Description	Indicate	Comments
Medical Record Review:	Illness in the last 30 days, serious life-threatening conditions?	Yes/No	List any medical concerns:
Physical Exam:	BMI: _____Healthy Value?	Yes/No	
	BP: _____Healthy Value?	Yes/No	
	Pulse rate: _____ Healthy Value?	Yes/No	
	Temperature: _____ Healthy Value?	Yes/No	
	Any abnormal physical symptoms, such as pain, rash, oral scars, jaundice, etc?	Yes/No	
Blood Type*:	**Type**: A: _____ B: _____ AB: _____ O: _____ **Lab Result Date*:**	**Rh Factor:** Present (+): _____Absent (-): _____ **Lab Result Date*:**	
Blood HLA testing*:	Results:		**Lab Result Date*:**
Confirm the absence of Infections by blood testing:	Hepatitis B test is Negative?	Yes/No	**Lab Result Date*:**
	Hepatitis C test is Negative?	Yes/No	**Lab Result Date*:**
	HIV test is Negative?	Yes/No	**Lab Result Date*:**
	CVM test is Negative?	Yes/No	**Lab Result Date*:**
	Syphilis test is Negative?	Yes/No	**Lab Result Date*:**
Influenza symptoms? Yes_____ No_____	Was influenza test performed? Yes: ___No: ___ If performed, is the Influenza test Negative?	Yes/No	**Lab Results Date*:**
COVID-19 symptoms? Yes_____ No_____	Was coronavirus test performed? Yes: ___No: ___ If performed, is the COVID-19 test Negative?	Yes/No	**Lab Results Date*:**
Confirm the absence of any other Infectious Disease	Any active or recent infectious disease?	Yes/No	**If yes,** describe: Infection Name: Year:
Confirm the absence of lipid disorders	Active or past history of lipedema, lipomatosis, or lipodystrophies?	Yes/No	
Cancer	Active cancer or past history of cancer diagnosis?	Yes/No	
Pregnancy	Pregnant?	Yes/No	
Blood disorders	Recent history of DVT or pulmonary embolism?	Yes/No	
Clotting Factor disorders	Currently taking anticoagulant medications or other as prescribed by a hematologist?	Yes/No	
Cardiovascular disease	Current heart or cardiovascular disease?	Yes/No	
Pulmonary disease	Active pulmonary disease or past history of pulmonary disease?	Yes/No	
Diabetes	Active or past history of diabetes?	Yes/No	
Kidney disease	Active or past history of kidney disease?	Yes/No	
Medication Review	Currently taking any medications?	Yes/No	If yes, list any medications name:

*** Copy of test results must be attached to this form.**

Completed By: _____Date:_____Surgeon's Name and Signature: _____
QA Reviewer Name: _____Date:_____ Signature: _____