

Medical and Social History Questionnaire – Living Donor

Date to be recorded YYYY / MM / DD

Donor Identification Number is the LHSC Medical Record Number

Thank you for coming forward as a potential living donor. This Questionnaire is one of the first steps in the assessment. You can complete the questionnaire electronically, or write your answers in and send by email, fax, or Canada Post. If you are completing it electronically, please follow these steps:

1. For answers requiring text, click near the front of the box and type in your answer. As you type, the space will expand to allow for longer answers.
2. Tick boxes can be answered by clicking on the appropriate box.
3. When complete, save as a document, and attach to a return email to our office.

MEDICAL AND SOCIAL QUESTIONNAIRE

Which organ are you considering to donate?

☐ Kidney ☐ Liver

CONTACT INFORMATION

Name: _____
First
Middle
Last

Preferred Name: _____ Health Card #: _____

Date of Birth: _____ Race/Ethnicity: _____
 (yyyy/mm/dd)

For office use only: Age: _____

Country of Birth: _____

Language Spoken: _____

Will you require an interpreter during the donation process? Yes No

Biological sex assigned at birth: _____

Gender Identity: _____ Preferred Pronouns: _____

Height: _____ Weight: _____ *For office use only: BMI:* _____

Blood Type: _____

Email Address: _____

Home Address: _____

Number Street City

Province Country Postal Code

Phone Numbers: Home: _____ Can we leave a message? Yes No

Cell: _____ Can we leave a message? Yes No

Primary Care Provider: Name: _____		
Address: _____		
Phone: _____	Fax: _____	

RECIPIENT INFORMATION

Do you have an intended recipient? If yes , what is the name of your intended recipient? What is your relationship to your intended recipient? What is your intended recipient's date of birth (if known)? What is the name of the disease that your intended recipient has? (if known) Have you discussed your wish to donate with the intended recipient? Yes No Have you discussed your wish to donate with your family/friends? Yes No Why do you wish to donate?	Yes No
If your intended recipient receives an organ from another donor, would you like us to contact you to share information about other potential opportunities to donate an organ?	Yes No

KIDNEY DONORS ONLY

What hospital/centre is your intended recipient being treated at? (if known)	
What is the name of your intended recipient's nephrologist? (if known)	

ALL DONORS – MEDICAL AND SOCIAL HISTORY QUESTIONNAIRE**General Health**

1.	Please describe your health. Include any history of major illnesses.
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2.	Do you have any allergies (e.g., medications, nuts, shellfish, bees/wasp stings, latex, dye.)? If yes, please list and describe what you are allergic to and what type of reaction you had (e.g. anaphylaxis, life threatening breathing problems, rash, etc.). Do you carry any epi pen? Yes No	Yes No																			
3.	Do you see a primary care provider, or specialist for any health concerns? If yes, please provide details.	Yes No																			
4.	Do you take any prescription medications, herbals or over the counter medications? If yes, what do you take and for what reason?	Yes No																			
5.	a) Have you ever been admitted to a hospital, or had any operations or surgical procedures?	Yes No																			
	If yes, please complete.																				
	<table border="1" style="width: 100%;"> <thead> <tr> <th data-bbox="164 1247 342 1289">Year</th> <th data-bbox="342 1247 894 1289">Reason for admission/Surgery/Procedure</th> <th data-bbox="894 1247 1287 1289">Surgeon/Specialist</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		Year	Reason for admission/Surgery/Procedure	Surgeon/Specialist																
Year	Reason for admission/Surgery/Procedure	Surgeon/Specialist																			

	b) Have you ever had a reaction to anaesthesia? If yes , please provide details.	Yes	No
	c) Has anyone in your family had problems with anaesthesia (e.g. malignant hypothermia)? If yes , please provide details.	Yes	No
6.	Has anyone in your family been diagnosed with or treated for any serious health issues (e.g. kidney disease, kidney stones, liver disease, heart disease, diabetes, cancer, strokes, blood clots, tuberculosis)? If yes , please provide details below.	Yes	No
	Maternal Grandmother:	Yes	No
	Maternal Grandfather:	Yes	No
	Paternal Grandmother:	Yes	No
	Paternal Grandfather:	Yes	No
	Mother:	Yes	No
	Father:	Yes	No
	Siblings:	Yes	No
	Children:	Yes	No
	Other Close Relatives (blood related aunts, uncles, cousins)	Yes	No

7.	a) Do you currently smoke tobacco? If yes, How many per day? For how long? b) If you currently do not smoke, have you smoked in the past? N/A If yes, How many per day? For how long? When did you quit?	Yes No Yes No												
8.	a) Do you currently drink alcohol? If yes, How often? How many drinks are consumed? b) If you currently do not drink alcohol, did you drink in the past? If yes, How much did you drink? For how long? When did you stop drinking? c) Have you ever been told by a healthcare professional to reduce or stop drinking? If yes, When? Did you attend a relapse prevention program?	Yes No Yes No Yes No Yes No												
9.	Have you used any recreational drugs? <table border="0"> <tr> <td>Cocaine</td> <td>Heroin</td> <td>Crack</td> <td>LSD</td> </tr> <tr> <td>Crystal meth</td> <td>Marijuana</td> <td>Hashish</td> <td>Speed</td> </tr> <tr> <td>Ecstasy</td> <td>Anabolic steroids</td> <td>Oxycodone</td> <td>Other</td> </tr> </table> If yes, Ingested (by mouth) Inhaled Intranasal (by nose) Injected (by needle) When and for how long?	Cocaine	Heroin	Crack	LSD	Crystal meth	Marijuana	Hashish	Speed	Ecstasy	Anabolic steroids	Oxycodone	Other	Yes No
Cocaine	Heroin	Crack	LSD											
Crystal meth	Marijuana	Hashish	Speed											
Ecstasy	Anabolic steroids	Oxycodone	Other											

10.	Do you have diabetes? <i>If yes</i> , Are you taking oral medication? Yes No Are you taking insulin injections? Yes No Have you ever been treated with injected bovine insulin? Yes No		Yes No
11.	Do you have a history of thyroid disease?		Yes No
12.	Have you received human growth hormone? If yes, was it prior to 1986 in Canada or the U.S.? <u>OR</u> at any time in a country other than Canada or the U.S.?	Yes No Yes No	Yes No
13.	Have you ever been diagnosed with an autoimmune disorder (e.g. lupus, Crohn's disease, rheumatoid arthritis)? <i>If yes</i> , what and when?		Yes No
Neurological and Psychological Health			
14.	Have you ever had a stroke? <i>If yes</i> , please provide details including when.		Yes No
15.	Have you been investigated for any degenerative neurological diseases of viral or unknown causes including, but not limited to dementia, epilepsy, Alzheimer's, MS, ALS (Lou Gehrig's disease), brain tumours, or Parkinson's? <i>If yes</i> , what were you investigated for and when?		Yes No

16.	a) Have you ever been diagnosed or investigated for any prion-related disease, including but not limited to Creutzfeldt-Jakob disease, variant Creutzfeldt-Jakob disease or other transmissible spongiform encephalopathies? b) Have you been tested for encephalitis or meningitis? If yes to a) or b), please provide details.	Yes No
		Yes No
17.	a) Have you ever been diagnosed with or treated for a psychiatric or emotional disorder? b) Have you ever seen a mental health professional, or are you currently seeing a mental health professional? c) Have you ever been prescribed anti-depressants, anti-anxiety or other similar medications? If yes to a), b), or c), please provide details.	Yes No
		Yes No
		Yes No
Cardiopulmonary Health (Heart and Lungs)		
18.	a) Do you have hypertension? (high blood pressure) If yes, when were you diagnosed with hypertension? Do you take blood pressure medication? If yes, what medications do you take?	Yes No
		Yes No

	b) Have you been advised to make lifestyle changes to improve your blood pressure, such as losing weight, salt restriction, etc? If yes, please provide details.	Yes No																
	Kidney Donors Only: Please have 3 blood pressure readings performed on different days. These can be obtained at your local pharmacy, your physician's office or on a home blood pressure cuff if you have access. <table border="1"> <thead> <tr> <th></th><th>Date</th><th>Location (where you are having your blood pressure taken)</th><th>Blood Pressure Reading</th></tr> </thead> <tbody> <tr> <td>#1</td><td></td><td></td><td></td></tr> <tr> <td>#2</td><td></td><td></td><td></td></tr> <tr> <td>#3</td><td></td><td></td><td></td></tr> </tbody> </table>		Date	Location (where you are having your blood pressure taken)	Blood Pressure Reading	#1				#2				#3				
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#2																		
#3																		
19.	Have you ever had: Chest pain Heart disease/failure Heart attack Irregular heart beat If yes, please provide details including when.	Yes No																
20.	Have you had: Asthma COPD Emphysema Other lung disease Sleep apnea Shortness of breath If yes, please provide details including when.	Yes No																
21.	Can you climb 4 flights of stairs or walk 4 blocks without stopping?	Yes No																

Blood Disorders		
22.	Have you ever had a blood clot or excessive bleeding? If yes , please provide details.	Yes No
23	Do you have a history of: Anemia Hemophilia Sickle Cell Thalassemia Other If yes , please provide details.	Yes No
24.	Have you or a sexual partner ever received intravenous treatment for haemophilia or other blood disorders? If yes , Have you ever received human-derived clotting factors? Yes No What and when?	Yes No
Liver and Gastrointestinal Health		
25.	Have you ever been tested, diagnosed with, or treated for digestive or intestinal disease (i. e., Crohn's, bloody stools, ulcerative colitis)? If yes , please provide details.	Yes No
26.	Have you ever had an endoscopy (scope) of your stomach or colon? If yes , why and when?	Yes No
27.	Have you ever had any gallbladder problems or gall stones? If yes , please provide details.	Yes No
28.	a) Have you ever been tested, diagnosed with or treated for liver disease?	Yes No
	b) Do you have any history of jaundice (yellow discoloration of skin or eyes)?	Yes No
	c) Is there any family history of liver disease (Wilson's Disease / hemochromatosis / alpha 1 antitrypsin deficiency / PBC / PSC / polycystic disease)?	Yes No
	If yes to any of the above , please provide details.	

29.	Have you ever been told you have any type of hepatitis? If yes , what type and when?	Yes	No
Kidneys and Reproductive Health			
30.	a) Have you ever had impaired kidney function, kidney stones or kidney infection? If yes , when and what treatment did you have?	Yes	No
	b) Have you ever had a bladder infection? If yes , please provide details.	Yes	No
	c) Have you ever had problems with your bladder such as incontinence or difficulty voiding? If yes , please provide details.	Yes	No
31.	a) Do you get regular PAP tests?	Yes	No
Females Only (Biological Sex at Birth)	If yes , When was your last test? Result:		
	b) Have you ever had a mammogram? If yes , When was your last mammogram? Result:	Yes	No
	c) Have you had any pregnancies?	Yes	No
	If yes , Were you ever diagnosed with gestational diabetes? Yes No If yes , did you require treatment (e.g. insulin)? Yes No Did you have high blood pressure, toxemia or pre-eclampsia during pregnancy? Yes No If yes , did it require treatment? Yes No If yes , what was the treatment?		
	d) Are you currently trying to become pregnant?	Yes	No
	e) Do you have any plans for future pregnancies?	Yes	No

32.	a) Do you have any problems related to your prostate? If yes , please provide details.	Yes	No
	b) Have you had a recent prostate/testicular exam or PSA level done? If yes , Date of test: _____ Result: _____	Yes	No
Cancer History			
33.	Have you ever been told you have any type of cancer (eg. carcinoma, melanoma, leukaemia or lymphoma)? If yes , when, what type and how were you treated?	Yes	No
34.	Have you been vaccinated for any reason in the last 12 months? If yes , which vaccination and when?	Yes	No
35.	Have you had <u>any</u> recent fevers or infections (including CMV and EBV)?	Yes	No
36.	Do you have <u>any</u> chronic infections (including CMV and EBV)?	Yes	No
37.	a) Have you been exposed to, diagnosed with or treated for tuberculosis? b) Have you had a TB skin test? If yes , Date of test: _____ Result: Positive Negative Unknown	Yes Yes	No No
38.	Do you have any suspected or confirmed diagnosis of an emerging (developing) infectious disease? If yes , what and when?	Yes	No
39.	Have you been diagnosed with rabies, or, within the past 6 months, been bitten by an animal and treated as if the animal was rabid? If yes , when, what kind of animal and was it known to have rabies?	Yes	No

46.	Have you received human (allogeneic) dura mater?	Yes	No
47.	Have you ever received blood transfusions or other blood products? <i>If yes, why, when and in which country?</i>	Yes	No
	Were any of the blood products from the UK/Europe since 1980?	Yes	No
48.	Have you ever been refused as a blood donor or asked not to donate? <i>If yes, why and when?</i>	Yes	No
Where Have You Lived and Travelled?			
49.	Have you <u>ever</u> lived outside of Canada? <i>If yes, where and when?</i>	Yes	No
50.	Have you <u>ever</u> travelled outside of Canada or the USA? <i>If yes, where and when?</i>	Yes	No
51.	If you have traveled to the United States, please list the states you have visited.		

52.	Have you ever been exposed to, diagnosed with, or suspected of having any of the following travel-related diseases? If yes , please provide details. Zika _____ Chagas Disease _____ Dengue _____ Ebola _____ Malaria _____ Strongyloides _____ Any other travel related diseases _____	Yes No
Health Canada Mandatory Donor Screening Questions: <i>Health Canada requires all donor programs to ask the following questions. Some of these questions may be of a sensitive nature and will be kept confidential. Any information that needs to be shared will require your written consent.</i>		
53.	Have you: a) in <u>the past 3 months</u> , used nonmedical intravenous, intramuscular or subcutaneous injection of drugs? b) In <u>the past 3 months</u> , have sex in exchange for money or drugs? c) In <u>the past 3 months</u> , have sex with any persons described in items a) and b), or with a person known or suspected to have HIV, or clinically active HBV or clinically active HCV? d) In <u>the past 3 months</u> have a new sexual partner and in <u>the past 3 months</u> have anal sex? e) In <u>the past 3 months</u> had more than one sexual partner and in <u>the past 3 months</u> have anal sex? f) In <u>the past 3 months</u> , used any drug, intranasally, for nonmedical/recreational reasons? <i>(Unless HCV NAT is performed and found to be negative)</i> g) In <u>the past 3 months</u> , have exposure, to known or suspected HIV-, HBV-, and/or HCV-infected blood through percutaneous inoculation or through contact with an open wound, nonintact skin, or mucous membrane? h) In <u>the past 3 months</u> , reside in a youth correctional facility, jail, or prison for more than 72 consecutive hours? i) In <u>the past 3 months</u> undergo tattooing, ear piercing, or body piercing in which sterile procedures were not used (e.g., contaminated instruments and/or ink were used, or shared instruments that had not been sterilized between uses were used) j) In <u>the past 3 months</u> , have close contact with another person having clinically active HBV or clinically active HCV infection (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurs regularly) k) In <u>the past 3 months</u> , taken any medication by mouth (oral) to prevent HIV infection. l) In <u>the past 2 years</u> , received any medication by injection to prevent HIV infection.	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No

ADDITIONAL INFORMATION			
54.	Who will be your primary support person (s) during the donation and recovery process? <i>(Please note: we encourage you to have a primary support person who would not also be the primary support person for your intended recipient.)</i>		
55.	Do you have any children or dependents?	Yes	No
56.	If during your surgery or recovery from donation, you needed a blood transfusion or blood products, would you be willing to accept these?	Yes	No
57.	What do you do for work?		
58.	a) Are you the sole wage earner in your household?	Yes	No
	b) Do you have benefits?	Yes	No
59.	Donating an organ requires time off work to recover (approximately 6–8 weeks for a kidney or 8-12 weeks for a liver). Do you think you are able to take this time off without affecting your position?	Yes	No
60.	Do you perform work, sports, or hobbies that require heavy lifting?	Yes	No
61.	Is there any reason why you think you should not be an organ donor? No explanation is necessary.	Yes	No
62.	Within what time frame are you hoping to complete this process? (i.e. When will be the best time for you to donate if you are found suitable?)		
Did you use an interpreter to complete this questionnaire?		Yes	No
If yes , name of interpreter:		Relationship:	
<i>I have answered the previous questions regarding my medical and social history accurately and understand that they are to ensure that I am healthy enough to be a donor and that I have no conditions that may pose a risk to me or the intended recipient.</i>			
Potential Donor Name: _____			
Signature: _____			
Date: _____			
Was this questionnaire completed by someone other than the potential donor?		Yes	No
If yes, why? _____			
If yes, name of person completing questionnaire on behalf of donor: _____			
signature of person completing questionnaire on behalf of donor: _____			
Date: _____			
For Office Use Only – to be completed by Living Donor Coordinator:			
Reviewed by:		_____	
Date:		_____	

CONSENT FOR LIVING DONATION ASSESSMENT

Date to be recorded: YYYY / MM / DD

Donor Identification Number is the LHSC Medical Record Number

I, _____,

NAME IN FULL OF POTENTIAL DONOR

have read the information about the living donation assessment process that was provided to me by the Living Donation Team. This includes the risks and potential consequences of the assessment process. I have the opportunity to ask questions about the assessment process and have had my questions answered to my satisfaction. I understand the information provided to me and I consent to living donor assessment including:

- I will have several tests and scans performed to ensure that I am in good health. These results will be shared with my primary health care provider and if necessary, a referral will be made to an additional health care provider as indicated.
- I understand that any abnormal test results discovered during assessment could impact the cost of my life insurance and potential job opportunities.
- I understand the living donor team may be sharing some of my health information with the transplant team caring for my intended recipient for the purposes of organizing and planning care.
- I understand that I will be tested for infectious diseases such as Syphilis, HIV, Hepatitis B and C. If I test positive for any of these tests, mandatory reporting to Public Health will occur.
- I understand that blood work will be done to assess compatibility between the donor and recipient. In the case of parent-child donation relationships, it may be discovered that the two are not biologically related. This information does not influence how well the organ does in the recipient. LHSC does not disclose information regarding biological relationships based on the results of our transplant testing.
- I understand that I am free to decide not to proceed with living donation at any time.
- If donation occurs, I will contact the donor team if there are any significant changes in my health. (e.g. a new diagnosis of an infectious disease or cancer) If these changes in my health could impact the health of the recipient, I consent to the sharing of this information with the recipient's transplant team and if necessary, the recipient.
- The Trillium Gift of Life Network Act states that "No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or blood constituent, for therapeutic purposes, medical education or specific research, and any such dealing is invalid as being contrary to public policy". I acknowledge and understand that buying and selling of organs in Canada is illegal. I have not and will not accept gifts and/or incentives, either directly or indirectly, as money or as any other gift or consideration of any kind as a result of donating my organ.
- There will be out-of-pocket expenses associated with living organ donation. There is a reimbursement program, PRELOD, which will help with some of the out-of-pocket expenses incurred during the donation process. I have been provided with this information.

Date: _____
YYYY/MM/DD

SIGNATURE OF POTENTIAL DONOR

I, _____,
NAME IN FULL OF LIVING DONOR COORDINATOR

have given information to the potential donor about the living donor process which includes the risks and potential consequences of the assessment. I have answered the questions of the potential donor to the best of my ability. To the best of my knowledge, the potential donor is giving their informed consent to assessment voluntarily.

Date: _____
YYYY/MM/DD

SIGNATURE OF LIVING DONOR COORDINATOR