London Health Sciences Centre

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: (yyyy/mm/dd) _____ Race/Ethnicity: _____

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.

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? ***If yes,*** please complete.	☐ Yes ☐ No

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? ☐ Cocaine ☐ Heroin ☐ Crack ☐ LSD ☐ Crystal meth ☐ Marijuana ☐ Hashish ☐ Speed ☐ Ecstasy ☐ Anabolic steroids ☐ Oxycodone ☐ Other ***If yes,*** ☐ Ingested (by mouth) ☐ Inhaled ☐ Intranasal (by nose) ☐ Injected (by needle) When and for how long?	☐ Yes ☐ No

10.	Do you have diabetes? ***If yes*,** 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.? ☐ Yes ☐ No <u>OR</u> at **any** time in a country other than Canada or the U.S.? ☐ Yes ☐ No	☐ Yes ☐ No
13.	Have you ever been diagnosed with an autoimmune disorder (e.g. lupus, Crohn's disease, rheumatoid arthritis)? ***If yes,*** what and when?	☐ Yes ☐ No
Neurological and Psychological Health		
14.	Have you ever had a stroke? ***If yes,*** 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? ***If yes,*** 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?	☐ Yes ☐ No
	b) Have you been tested for encephalitis or meningitis? ***If yes to a) or b),*** please provide details.	☐ Yes ☐ No
17.	a) Have you ever been diagnosed with or treated for a psychiatric or emotional disorder?	☐ Yes ☐ No
	b) Have you ever seen a mental health professional, or are you currently seeing a mental health professional?	☐ Yes ☐ No
	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
Cardiopulmonary Health (Heart and Lungs)		
18.	a) Do you have hypertension? (high blood pressure) ***If yes***, when were you diagnosed with hypertension?	☐ Yes ☐ No
	Do you take blood pressure medication? ***If yes,*** what medications do you take?	☐ Yes ☐ No

<table>
<tr><td></td><td>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.</td><td>☐ Yes ☐ No</td></tr>
<tr><td></td><td><u>Kidney Donors Only:</u> 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><tr><th></th><th>Date</th><th>Location (where you are having your blood pressure taken)</th><th>Blood Pressure Reading</th></tr><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></table></td><td></td></tr>
<tr><td>19.</td><td>Have you ever had:
☐ Chest pain ☐ Heart disease/failure ☐ Heart attack ☐ Irregular heart beat
If yes, please provide details including when.</td><td>☐ Yes ☐ No</td></tr>
<tr><td>20.</td><td>Have you had:
☐ Asthma ☐ COPD ☐ Emphysema ☐ Other lung disease ☐ Sleep apnea
☐ Shortness of breath
If yes, please provide details including when.</td><td>☐ Yes ☐ No</td></tr>
<tr><td>21.</td><td>Can you climb 4 flights of stairs or walk 4 blocks without stopping?</td><td>☐ Yes ☐ No</td></tr>
</table>

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? ***If yes,*** When was your last test? Result:	☐ Yes ☐ No
Females Only (Biological Sex at Birth)	b) Have you ever had a mammogram? ***If yes,*** When was your last mammogram? Result:	☐ Yes ☐ No
	c) Have you had any pregnancies? ***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?	☐ Yes ☐ No
	d) Are you currently trying to become pregnant?	☐ Yes ☐ No
	e) Do you have any plans for future pregnancies?	☐ Yes ☐ No

32. Males Only (Biological Sex at Birth)	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 ☐ No ☐ Yes ☐ 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

40.	Have you been diagnosed with a communicable disease – viral bacterial, or fungal (e.g. H1N1, Swine flu, measles, cold sores)? ***If yes,*** what and when?	☐ Yes ☐ No
41.	Have you been diagnosed with an STI (sexually transmitted infection – e.g. syphilis, herpes, gonorrhea)? ***If yes,*** what and when?	☐ Yes ☐ No
42.	Have you had any recent skin changes (open sores, rashes or infected cuts) unexplained lymphadenopathy mass (enlarged lymph nodes) or mucocutaneous (inside your mouth) lesions?	☐ Yes ☐ No
43.	Have you ever test positive for: ☐ HIV or AIDS or ☐ HTLV? ***If yes****,* please provide details.	☐ Yes ☐ No
44.	a) In <u>the past 6 months</u>, have you had any unexplained weakness or flu-like symptoms such as fever, headache, nausea, vomiting, persistent diarrhea, swollen lymph nodes, confusion, muscle, joint or neck pain, fatigue, rash or sensitivity to light? ***If yes,*** what and when? Did these symptoms start after a mosquito had bitten you or you had been exposed to mosquitoes? ***If yes,*** how long after the mosquito bite did the symptoms start? b) In the past 120 days (3 months) have you either had a suspected case, or been diagnosed with WNV? c) Have you had close contact with someone who has had either a suspected or diagnosed case of WNV? ***If yes,*** when?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
45.	Have you ever received an organ or tissue transplant (eg. bone, cornea, skin, heart, kidney, liver, lung, bone marrow)? ***If yes,*** what type and when?	☐ Yes ☐ No

46.	Have you received human (allogeneic) dura mater?	☐ Yes ☐ No
47.	Have you ever received blood transfusions or other blood products? ***If yes,*** why, when and in which country? Were any of the blood products from the UK/Europe since 1980? ☐ Yes ☐ No	☐ Yes ☐ No
48.	Have you ever been refused as a blood donor or asked not to donate? ***If yes,*** why and when?	☐ Yes ☐ No
Where Have You Lived and Travelled?		
49.	Have you **ever** lived outside of Canada? ***If yes,*** where and when?	☐ Yes ☐ No
50.	Have you **ever** travelled outside of Canada or the USA? ***If yes,*** where and when?	☐ 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: *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.*		
53.	Have you:	
	a) in the past 3 months, used nonmedical intravenous, intramuscular or subcutaneous injection of drugs?	☐ Yes ☐ No
	b) In the past 3 months, have sex in exchange for money or drugs?	☐ Yes ☐ No
	c) In the past 3 months, 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?	☐ Yes ☐ No
	d) In the past 3 months have a new sexual partner and in the past 3 months have anal sex?	☐ Yes ☐ No
	e) In the past 3 months had more than one sexual partner and in the past 3 months have anal sex?	☐ Yes ☐ No
	f) In the past 3 months, used any drug, intranasally, for nonmedical/recreational reasons? *(Unless HCV NAT is performed and found to be negative)*	☐ Yes ☐ No
	g) In the past 3 months, 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?	☐ Yes ☐ No
	h) In the past 3 months, reside in a youth correctional facility, jail, or prison for more than 72 consecutive hours?	☐ Yes ☐ No
	i) In the past 3 months 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)	☐ Yes ☐ No
	j) In the past 3 months, 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)	☐ Yes ☐ No
	k) In the past 3 months, taken any medication by mouth (oral) to prevent HIV infection.	☐ Yes ☐ No
	l) In the past 2 years, received any medication by injection to prevent HIV infection.	☐ Yes ☐ No

ADDITIONAL INFORMATION		
54.	Who will be your primary support person (s) during the donation and recovery process? *(Please note: we encourage you to have a primary support person who would not also be the primary support person for your intended recipient.)*	
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 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.

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**