

Living Donor Transplant Program
Donor Health History

Please complete all sections and submit this form along with a copy of your blood type to the assessment office.

Name (As written on your Ontario health card or government issued ID):
<i>Preferred Name (if applicable):</i>

Office use only	
Date Received: _____ <i>dd/mm/yyyy</i>	Date Entered in OTTR: _____ <i>dd/mm/yyyy</i>
Date ABO Received: _____ <i>dd/mm/yyyy</i>	
Date Reviewed: _____ <i>dd/mm/yyyy</i>	MRN: _____ TGLN: _____

DEMOGRAPHICS				
Provincial Health Card Number: <input type="checkbox"/> N/A		Date of Birth: <i>dd/mm/yyyy</i>	<i>Office use only</i> Age:	
Marital Status: <i>(Please Circle)</i> Married / Single / Divorced / Widowed / Other		Blood Type: A / B / AB / O Positive / Negative I have attached a copy of my blood type <input type="checkbox"/>		
Sex: Male / Female	Height: _____ in / cm	Weight: _____ lbs / kg	<i>Office use only</i> BMI:	
Country of Birth:		Citizenship:		Race/Ethnicity:
<i>Street No and Name Apt No City Province Postal Code</i>				
Address:				
Home Telephone: ()			Cell Telephone: ()	
Email Address:				
Occupation:		Work Telephone: () Can we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family Doctor:		Telephone: ()		
<i>Street No and Name Apt No City Province Postal Code</i>				
Address:				
Which organ/tissue do you wish to donate: <input type="checkbox"/> Conjunctival Limbal Stem Cell (Eye) <input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Lung				
Please indicate the name of the recipient to whom you wish to direct your donation: <input type="checkbox"/> N/A			<i>Office use only</i>	
Date of Birth (dd/mm/yyyy):			MRN ABO	
What is your relationship to the recipient? <input type="checkbox"/> Anonymous				
Is your recipient a patient at: <input type="checkbox"/> Toronto General <input type="checkbox"/> Toronto Western <input type="checkbox"/> Sick Kids <input type="checkbox"/> N/A				

Name:

Have you discussed your wish to donate with the intended recipient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Have you discussed your wish to donate with your family / friends?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Why do you wish to donate?			

Medical History:

These questions are used to gather important information about your health and lifestyle that might impact on your potential to become a living donor. This information will be used by the health care professionals on our team to determine your overall well being. All information on this questionnaire is kept strictly confidential.

GENERAL HEALTH:		
1.	Have you ever had any abdominal surgery? (gallbladder, appendix, bowel) If yes, what type, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever had any other surgery? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Did you have any problems after surgery/anesthetic? If yes, what were the problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you had any hospitalization for other reasons? If yes, when and why? Name of Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you routinely take any medications (including prescriptions, over the counter, vitamins and herbal supplements)? If yes, list:	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you have any allergies? If yes, to what? If yes, what type of reaction and symptoms do you have? If yes, do you carry an EpiPen? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name : _____

7.	Do you currently smoke or have you ever smoked? If yes , what (cigarettes, pipe, cigars)? How many per day? For how long? Years If you have quit, when did you quit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Do you drink alcohol? How many drinks per week (1 drink = 1 bottle of beer, 1 glass of wine or 1 ½ oz of spirits)? For how long?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you had any recent unexplained weight loss? If yes , explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
LIVER HEALTH		
10.	Have you ever had jaundice (yellow skin)? If yes , when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have you ever had a liver problem? If yes , what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Is there a family history of liver problems? If yes , what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CANCER HISTORY		
13.	Have you had cancer? If yes , Type? When? Treatment: Radiation <input type="checkbox"/> Chemo <input type="checkbox"/> Surgery <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">**</p>
14.	Do you have a family history of cancer? If yes , who? What type of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name: _____

INFECTION RISKS:		
15.	Have you ever received a blood transfusion or other blood product? If yes, type? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Have you, in the last 12 months, had a tattoo, 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)? If yes, what? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
17.	Do you have a chronic infection of any type? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Have you ever had a communicable disease (such as Mono) If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Do you have or have you ever had any history of syphilis? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
20.	In the past 12 months have you had close contact with another person having clinically active viral hepatitis (e.g. living in the same household, where sharing of kitchen and bathroom facilities occurs regularly?)	<input type="checkbox"/> Yes <input type="checkbox"/> No **
21.	In the past six months have you been bitten by an animal? If yes, please describe: Were you treated as if the animal was rabid or diagnosed with rabies?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No **

Name: _____

22.	<p>Do you currently use or have you ever used nonmedical or recreational/ street drugs (ingested, inhaled, subcutaneous, intramuscular or intravenous drugs e.g. LSD, marijuana, hash, cocaine)?</p> <p>If yes, what and when? </p> <p>Have you ever had treatment for this? If yes, what treatment and when? </p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">**</p>
23.	<p>Have you been treated for any infection in the past 12 months?</p> <p>If yes, what? When?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
24.	<p>Have you ever tested positive for HIV?</p> <p>If yes, when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
25.	<p>Have you had any recent vaccinations?</p> <p>If yes, what and when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
26.	<p>Have you been vaccinated for Hepatitis B?</p> <p>If yes, when or at what age?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
27.	<p>Have you ever been suspected of having West Nile Virus or been diagnosed with West Nile Virus?</p> <p>If yes, when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
28.	<p>Within the last 6 months have you traveled to other parts of Canada, or any where outside of Canada (including the US)?</p> <p>If yes, where and when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>Office use only: Review current travel health notices - http://www.phac-aspc.gc.ca/tmp-pmv/notices-avis/index-eng.php If traveling to a WNV endemic area, during non WNV testing season - http://www.cdc.gov/westnile/index.html http://www.phac-aspc.gc.ca/wnv-vwn/index-eng.php</p>	
29.	<p>Have you ever lived outside of Canada?</p> <p>If yes, where and when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Name: _____

30.	Have you ever received human growth hormone? If yes, was it prior to 1986 within Canada or the US OR at any time outside Canada or the US?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No **
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31.	Have you ever received dura mater?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
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NEUROLOGICAL/PSYCHOLOGICAL

32.	Do you have a seizure disorder/epilepsy? Please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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33.	Have you ever had a stroke/transient ischemic attack? If yes when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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34.	Have you been diagnosed with or been investigated for any degenerative neurological diseases such as dementia, Alzheimer's, Creutzfeldt-Jakob (CJD) disease (Mad Cow), brain tumours, Parkinson's disease, Lou Gehrig's, Multiple Sclerosis? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
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35.	Have you ever had treatment for depression? When? Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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36.	Have you ever had treatment for a psychiatric problem? When? Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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CARDIOVASCULAR

37.	Do you have a history of heart disease or chest pain? If yes, elaborate:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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38.	Have you ever had high blood pressure? If yes, when? Type of treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Name:

39.	Have you had a heart attack? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
40.	Have you ever had rheumatic fever, or been told you have a heart murmur? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
41.	Have you ever had palpitations or been told that you have a heart arrhythmia? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEMATOLOGY/BLOOD		
42.	Do you and/or a family member have hemophilia or a clotting problem? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
43.	Have you ever received human-derived clotting factor concentrates? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
44.	Have you or any of your family members had a problem with excessive bleeding? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
45.	Have you had excessive bleeding with any surgery or dental extractions? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
46.	Have you and/or a family member ever had a blood clot in your lungs or legs? If yes, what? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
RESPIRATORY		
47.	Have you ever had any lung disease such as asthma or emphysema? If yes, what? When? Any treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name: _____

48.	Have you ever been exposed to someone with tuberculosis or had a positive TB skin test yourself? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
49.	Do you routinely use any inhalers or take medications to help your breathing? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
50.	Have you ever been suspected of having SARS (Severe Acute Respiratory Syndrome) or been diagnosed with SARS? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
51.	Do you have sleep apnea or use a CPAP machine? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No

GASTROINTESTINAL

52.	Do you have any stomach or intestinal problems? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
53.	Have you ever had gallbladder problems or gallstones? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
54.	Have you ever had a colonoscopy or gastroscopy? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No

GENITOURINARY

55.	Have you ever had problems with your kidneys (such as infections or stones)? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
56.	Have you ever had any problems with your bladder (such as infections, incontinence or difficulty voiding)? If yes, please describe. When?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name: _____

57.	For Men Only: Do you have any problems related to an enlarged prostate? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
58.	For Females Only : Date of Last Menstrual Period: Date of last PAP smear <input type="checkbox"/> N/A Date of last breast exam or mammogram: <input type="checkbox"/> N/A	<input type="checkbox"/> N/A
59.	For Females Only: Have you ever had a gynecologic problem? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
60.	For Females Only: Have you had any pregnancies? If yes, did you experience any problems with your pregnancies or deliveries (such as high blood pressure, toxemia or high blood sugar)? If yes, please describe?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
61.	For Females Only: Are you currently trying to become pregnant or do you have plans for future pregnancies?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
ENDOCRINE		
62.	Do you have diabetes? Type? Onset?	<input type="checkbox"/> Yes <input type="checkbox"/> No
63.	Do you have a family history of diabetes? If yes, who?	<input type="checkbox"/> Yes <input type="checkbox"/> No
64.	Have you ever had increased blood sugars (i.e., with pregnancy)? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
65.	Have you ever been diagnosed with thyroid disease? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
SOCIAL		
66.	Does your family have a history of any serious health issues? (i.e. heart disease, strokes, Creutzfeldt-Jakob (Mad Cow) disease) If yes, please outline:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name:

67.	Are you the sole wage earner in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No
68.	Donating an organ or tissues requires approximately time off work to recover. Do you think you are able to take time off work? A. 4 – 8 weeks for a kidney or portion of liver B. Up to a week for Conjunctival Limbal Stem Cell (Eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No
We are required to ask the following questions to meet government regulations. We acknowledge that these are of a sensitive nature and all information will be kept strictly confidential. If you have any questions, please speak with a member of the living donor team		
69.	In the past 12 months, have you been exposed to known or suspected HIV, Hepatitis B and/or Hepatitis C infected blood through skin punctures, or through contact with an open wound, non-intact skin, or mucous membrane?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
70.	In the past 5 years, have you ever had sex in exchange for money or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
71.	In the past 5 years, did any of your sexual partners have sex in exchange for money or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
72.	In the past 12 months, did you have sex with any person known or suspected to have clinically active hepatitis or HIV infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
73.	In the past 5 years have you or any sexual partner used a needle to inject drugs into your veins, muscles or under the skin, for non-medical use?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
74.	For Females: Have you had sex with a man who in the past 5 years had sex with another man?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A **
75.	For Males: Have you had sex with another man in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A **
76.	Have you been in juvenile detention, lock up, jail or prison for more than 72 consecutive hours in the preceding 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
OTHER		
77.	Is there any other information that we should know? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
78.	Having answered all questions about medical conditions and behavioural risk factors is there any reason why you think you should not be an organ donor? You do not have to give an explanation for your answer.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have answered these questions to the best of my ability.

Name of Potential Donor

Signature of Potential Donor

dd/mm/yyyy

Office Use Only:

Based on the review of the Health History, this Potential Donor is:

Suitable for assessment Not Suitable for assessment Reason:.....

Comments:

Name of Person Administering and Reviewing
Questionnaire

Signature

dd/mm/yyyy

Please return your completed health history and a copy of your blood type to:

**Living Donor Assessment Office
Peter Munk Building, 12C – 1217
Toronto General Hospital
585 University Avenue,
Toronto, ON
M5G 2N2**

Or you can fax your information to the appropriate number below:

**Kidney Office: 416-340-5209
Liver/Eye (Conjunctival Limbal) Office: 416-340-4317
Lung Office: 416-340-3097**

