Living Donor Transplant Program
Donor Health History Form

PLEASE SUBMIT A COPY OF YOUR BLOOD TYPE TO THE OFFICE WITH THIS FORM.

This section in grey is for office use only:

Date Received: ____________________ *dd/mmm/yyyy*   Date Entered in OTTR: ___________________ *dd/mmm/yyyy*

Date ABO Received: _________________ *dd/mmm/yyyy*   Date Reviewed: ________________________ *dd/mmm/yyyy*

Donor: MRN ____________________ TGLN:___________ ABO ___________

Recipient: MRN ____________________ TGLN:___________ ABO ___________

What organ/tissue do you wish to donate?: □ Liver □ Kidney □ Conjunctival Limbal Stem Cell (Eye) □ Lung

DEMOGRAPHICS: Please complete the questionnaire in pen and in its entirety in order to be processed

First Name (Legal):	Middle Name (Legal):	Surname (Legal):
Preferred Name (if applicable):	Date of Birth: ________/________/________ dd mmm yyyy	Age:
Provincial Health Card Number: □ N/A	Health Insurance Card Expiry Date: □ N/A ________/________/________ yyyy mm dd	
Marital Status: *(Please Circle)* Married / Single / Divorced / Widowed / Other:	Blood Type: A / B / AB / O Positive / Negative I have attached a copy of my blood type ☐	
Sex: Male / Female	Height: ________ in / cm	Weight: _________ lbs / kg
Office use only BMI:		
Country of Birth:	Citizenship:	Race/Ethnicity:
Spoken language(s):	Preferred Language:	
Address: *Street # and Name* *Apt #* *City* *Province* *Postal Code*		
Home Telephone:	Cell Telephone:	
Email Address:		
What is your Occupation? Work Telephone:	Can we contact you at work? □ Yes □ No How do you prefer to be contacted?	
Family Doctor:	Family Doctor Telephone:	
Address: *Street # and Name* *Unit #* *City* *Province* *Postal Code*		

Please print your full name in the indicated section at the top of each page of this questionnaire

Name (First, Last) :

Do you have an **intended recipient** *(someone you want to donate to)?* **If yes,** what is the recipient's name? ______ If you know the recipient's date of birth, please indicate: ______ How do you know the recipient? ______	☐ Yes ☐ No	***Office use only*** MRN ABO
Have you discussed your wish to donate with the intended recipient?	☐ Yes ☐ No ☐ N/A	
Why do you wish to donate?		

Medical History Section: 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? …………	☐ Yes ☐ No
2.	Have you ever had any other surgery? **If yes,** what and when?…………	☐ Yes ☐ No
3.	Did you have any problems after surgery/anesthetic? **If yes,** what were the problems?…………	☐ Yes ☐ No
4.	Have you had any hospitalization for other reasons? **If yes,** when and why? ………… Name of Hospital: …………	☐ Yes ☐ No
5.	Do you routinely take any medications (including prescriptions, over the counter (OTC), vitamins and herbal supplements)? **If yes,** list: …………	☐ Yes ☐ No
6.	Do you have any allergies? **If yes**:	☐ Yes ☐ No

Allergy	**Symptom/Reaction**
1.	
2.	
3.	
4.	

If yes, do you carry an EpiPen? ☐ Yes ☐ No

Name (First, Last) :

7.	Do you currently smoke or have you ever smoked any tobacco products? **If yes,** what type (cigarettes, pipe, cigarillos, cigars)? **(circle one)** How many? ……………………………. per day/week/month/year **(circle one)** When did you start? ………………………….. If you have quit, when did you quit? ………………………………………………	☐ Yes ☐ No
8.	Do you drink alcohol? **If yes**, how many drinks **per week** (1 drink = 1 bottle of beer, 1 glass of wine or 1 ½ oz. of spirits)? ……………………………………………………….. Since when? …………………………….	☐ Yes ☐ No
LIVER HEALTH		
9.	Have you ever had jaundice (yellow skin)? **If yes,** when? ……………………………………………………………………………….	☐ Yes ☐ No
10.	Have you ever had a liver problem? **If yes,** what and when? ……………………………………………………………………………….	☐ Yes ☐ No
11.	Is there a family history of liver problems? **If yes,** what? ………	☐ Yes ☐ No
CANCER HISTORY		
12.	Have you had cancer? **If yes,** Type? ………………………………………. When? ……………………….. Treatment: Radiation ☐ Chemo ☐ Surgery ☐ Other:	☐ Yes ☐ No **
13.	Do you have a family history of cancer? **If yes,** who? ………………………………………………………………………………. What type of cancer? ……………………………………………………………………………….	☐ Yes ☐ No

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Name (First, Last) :

INFECTION RISKS		
14.	Have you ever received a blood transfusion or other blood product? **If yes,** type? …………………………………………………………………………………… When? ……………………………………………………………………………………	☐ Yes ☐ No
15.	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? ……………………………………………………………………………………	☐ Yes ☐ No **
16.	Do you have a chronic infection of any type? **If yes,** what and when? ……………………………………………………………………………………	☐ Yes ☐ No
17.	Have you ever had a communicable disease (such as Mono, Ebola, etc.)? **If yes,** what and when? ……………………………………………………………………………………	☐ Yes ☐ No
18.	Do you have or have you ever had any history of syphilis? **If yes,** when? ……………………………………………………………………………………	☐ Yes ☐ No **
19.	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?)	☐ Yes ☐ No **
20.	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?	☐ Yes ☐ No ☐ Yes ☐ No **

Name (First, Last) :

21.	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)? **If yes,** what is your **current** consumption?.. **If not current**, what was your previous consumption?.......................... Have you ever had treatment for this? **If yes,** what treatment and when?...	☐ Yes ☐ No ☐ Yes ☐ No **
22.	Have you been treated for any infection in the past 12 months? **If yes,** what? ………………………………………….……. When? ……………………	☐ Yes ☐ No
23.	Have you ever tested positive for HIV? **If yes,** when? …………………………………………………………………………………….	☐ Yes ☐ No
24.	Have you had any recent vaccinations? **If yes,** what vaccination?……………………………………………………. When?…………………….	☐ Yes ☐ No
25.	Have you been vaccinated for Hepatitis B? **If yes,** when? ……………………………….….	☐ Yes ☐ No
26.	Have you ever been suspected of having West Nile Virus (WNV) or been diagnosed with West Nile Virus within the last 120 days, or traveled in the preceding 56 days to areas where WNV is endemic? **If yes,** when? …………………………………………………………………………………….	☐ Yes ☐ No
27.	Within the last **6 months** have you traveled to other parts of Canada, or anywhere outside of Canada (including the US)? **If yes:**	☐ Yes ☐ No
28.	Have you ever lived outside of Canada for a period longer than 1 month? **If yes,** where? ………………………………………………… When?………………………………….	☐ Yes ☐ No

Where?	When?
1.	
2.	
3.	
4.	

Name (First, Last) :

29.	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?	☐ Yes ☐ No ☐ Yes ☐ No **
30.	Have you ever received dura mater (i.e. received a graft during neurosurgery)?	☐ Yes ☐ No **
NEUROLOGICAL/PSYCHOLOGICAL		
31.	Do you have a seizure disorder/epilepsy? Please provide details. …………………………………………………………………………………….	☐ Yes ☐ No
32.	Have you ever had a stroke/transient ischemic attack (TIA)? If yes when? …………………………………………………………………………………….	☐ Yes ☐ No
33.	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 condition and when? …………………………………………………………………………	☐ Yes ☐ No **
34.	Have you ever had treatment for depression? When? ………………………………… What type of treatment: …………………………………………………………………………………….	☐ Yes ☐ No
35.	Have you ever had treatment for a psychiatric problem? When? ………………………………… What type of treatment: …………………………………………………………………………………….	☐ Yes ☐ No
CARDIOVASCULAR		
36.	Do you have a history of heart disease or chest pain? **If yes,** elaborate: …………………………………………………………………………………….	☐ Yes ☐ No
37.	Have you ever had high blood pressure? **If yes,** when and type of treatment? …………………………………………………………….	☐ Yes ☐ No

Name (First, Last) :

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

Name (First, Last) :

47.	Have you ever been exposed to someone with tuberculosis or had a positive TB skin test yourself? **If yes,** when? ……………………………………………………………………………………	☐ Yes ☐ No
48.	Do you routinely use any inhalers or take medications to help your breathing? **If yes,** what? ……………………………………………………………………………………	☐ Yes ☐ No
49.	Do you have sleep apnea or use a CPAP machine? **If yes,** please describe: ……………………………………………………………………………………………………	☐ Yes ☐ No
GASTROINTESTINAL		
50.	Do you have any stomach or intestinal problems? **If yes,** what? ……………………………………………………………………………………	☐ Yes ☐ No
51.	Have you ever had gallbladder problems or gallstones? **If yes,** when? ……………………………………………………………………………………	☐ Yes ☐ No
52.	Have you ever had a colonoscopy or gastroscopy? **If yes,** when? ……………………………………………………………………………………	☐ Yes ☐ No
GENITOURINARY		
53.	Have you ever had problems with your kidneys (such as infections or stones)? **If yes,** what and when? ……………………………………………………………………………………	☐ Yes ☐ No
54.	Have you ever had any problems with your bladder (such as infections, incontinence or difficulty voiding)? **If yes,** please describe. …………………………………………………………………………………… When? ………………………………………………………………	☐ Yes ☐ No

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Name (First, Last) :

55.	**For MEN only:** Do you have any problems related to an enlarged prostate? **If yes,** what? ………………………………..	☐ Yes ☐ No ☐ N/A
56.	**For WOMEN only:** Date of Last Menstrual Period: ………………………….. Date of last PAP smear …………………………………… ☐ N/A Date of last breast exam or mammogram: ……………………………… ☐ N/A	☐ N/A
57.	**For WOMEN only:** Have you ever had a gynecologic problem? **If yes,** what? …………………………………………………………………	☐ Yes ☐ No ☐ N/A
58.	**For WOMEN 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? ………………………………………………………………	☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No
59.	**For WOMEN only:** Are you currently trying to become pregnant or do you have plans for future pregnancies?	☐ Yes ☐ No ☐ N/A
ENDOCRINE		
60.	Do you have diabetes? Type? ………………………………………………….. Onset? …………………………………………………	☐ Yes ☐ No
61.	Do you have a family history of diabetes? **If yes,** who? ………………………………………………………………………………	☐ Yes ☐ No
62.	Have you ever had increased blood sugars (i.e., with pregnancy)? **If yes,** please describe: ………………………………………………………………	☐ Yes ☐ No
63.	Have you ever been diagnosed with thyroid disease? **If yes,** what and when? ……………………………………………………………	☐ Yes ☐ No
SOCIAL		
64.	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: ………………………………………………………………………	☐ Yes ☐ No

Name (First, Last):

65.	Are you the sole wage earner in your household?	☐ Yes ☐ No
66.	Donating an organ or tissues requires approximately time off work to recover. Are able to take time off work? • 4 – 8 weeks for a kidney or portion of liver • Up to one (1) week for Conjunctival Limbal Stem Cell (Eye)	☐ Yes ☐ 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.		
67.	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?	☐ Yes ☐ No **
68.	In the past 5 years, have you ever had sex in exchange for money or drugs?	☐ Yes ☐ No **
69.	In the past 6 months, have you had a history of intranasal cocaine use?	☐ Yes ☐ No **
70.	In the past 5 years, did any of your sexual partners have sex in exchange for money or drugs?	☐ Yes ☐ No **
71.	In the past 12 months, did you have sex with any person known or suspected to have HIV, or clinically active Hepatitis B or C?	☐ Yes ☐ No **
72.	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?	☐ Yes ☐ No **
73.	**For WOMEN only**: In the past 12 months have you had sex with a man who in the past 12 months had sex with another man?	☐ Yes ☐ No ☐ N/A **
74.	**For MEN only**: Have you had sex with another man in the past 12 months?	☐ Yes ☐ No ☐ N/A **
75.	Have you been in a youth correctional facility, jail, or prison for more than 72 consecutive hours in the preceding 12 months?	☐ Yes ☐ No **
OTHER		
76.	Is there any other information that we should know? **If yes,** what? ………………………………………………………………………………	☐ Yes ☐ No
77.	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.**	☐ Yes ☐ No

I have answered ALL questions completely and to the best of my knowledge and ability.

Name of Potential Donor	**Signature of Potential Donor**	**Date** ***(dd/mmm/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**	**Date** ***(dd/mmm/yyyy)***

For potential **KIDNEY Donors** send to:

livingdonorkidney@uhn.ca or fax to 416-340-3009

Toronto General Hospital, University Health Network
585 University Avenue
Peter Munk Building
12th Floor Room 100 G
Toronto, ON M5G 2N2
Tel: 416-340-4800 ext. 4848

For potential **LIVER Donors** send to:

livingdonorliver@uhn.ca or fax to 416-340-4317

Toronto General Hospital, University Health Network
585 University Avenue
Peter Munk Building
12th Floor Transplant Clinic
Toronto, ON M5G 2N2
Tel: 416-340-4800 ext.6581

For potential **CONJUNCTIVAL LIMBAL Donors**:

Fax to 416-340-4317

Toronto General Hospital, University Health Network
585 University Avenue
Peter Munk Building
12th Floor Transplant Clinic
Toronto, ON M5G 2N2
Tel: 416-340-4800 ext. 6707

For potential **LUNG Donors**:

Fax to 416-340-3097

Toronto General Hospital, University Health Network
585 University Avenue
Peter Munk Building 12th
Floor Transplant Clinic
Toronto, ON M5G 2N2
Tel: 416-340-4800 ext. 3807