

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: _____ <i>dd/mmm/yyyy</i>	Date Entered in OTTR: _____ <i>dd/mmm/yyyy</i>	
Date ABO Received: _____ <i>dd/mmm/yyyy</i>	Date Reviewed: _____ <i>dd/mmm/yyyy</i>	
Donor: MRN _____	TGLN: _____	ABO _____
Recipient: MRN _____	TGLN: _____	ABO _____ (<input type="checkbox"/> N/A, if Anonymous)

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): _____	Preferred Pronoun: <i>(Please circle)</i> He / She / They / Ze / Zie / Xe / Sie / Hir / Ey / Open		Date of Birth: _____ / _____ / _____ <i>dd mmm yyyy</i>		Age: _____
Provincial Health Card Number: <input type="checkbox"/> N/A			Health Insurance Card Expiry Date: <input type="checkbox"/> N/A _____/_____/_____ <i>yyyy mmm dd</i>		
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 at birth: <i>(Please circle)</i> Male / Female	Height: _____ cm OR _____ ft _____ in	Weight: _____ kg OR _____ lbs	Office use only BMI: _____		
Gender: <i>(Please Circle)</i> Man / Woman / Gender-fluid / Non-binary / Trans man / Trans woman / Two-spirit / Prefer not to answer / Do not know / Not listed: _____					
Country of Birth: _____		Citizenship: _____		Race/Ethnicity: _____	
Spoken language(s): _____			Preferred Language: _____		
Address: _____ <i>Street # and Name</i>		_____ <i>Apt #</i>		_____ <i>City</i>	
_____ <i>City</i>		_____ <i>Province</i>		_____ <i>Country</i>	
_____ <i>Postal Code</i>					
Home Telephone: _____	Cell Telephone: _____	Email Address: _____			
What is your Occupation? _____			Can we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Work Telephone: _____			How do you prefer to be contacted? _____		
Family Doctor: _____			Family Doctor Telephone: _____		
Address: _____ <i>Street # and Name</i>		_____ <i>Unit #</i>		_____ <i>City</i>	
_____ <i>Province</i>		_____ <i>Postal Code</i>			

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? <u>Karen Andrea Marie Browns</u> If you know the recipient's date of birth, please indicate: <u>11/23/1968</u> How do you know the recipient? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Office use only MRN ABO <input type="checkbox"/> N/A – Anonymous
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 expressed your interest in donation to your family/friends and are they supportive of this decision?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.

A. GENERAL HEALTH:																							
1.	Do you see a nurse, family doctor or specialist for any ongoing health concerns? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
2.	Have you ever had any major illnesses? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
3.	Have you ever had any abdominal surgery? (gallbladder, appendix, bowel, etc.) If yes, what type, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
4.	Have you ever had any other surgeries or hospitalizations? <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Year</th> <th style="width: 45%;">Procedure/Reason</th> <th style="width: 40%;">Name of Hospital</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	Procedure/Reason	Name of Hospital																			<input type="checkbox"/> Yes <input type="checkbox"/> No
Year	Procedure/Reason	Name of Hospital																					
5.	Did you have any problems after surgery/anesthetic? If yes, what were the problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																					

Name (First, Last) :

B. LIVER HEALTH

1.	Do you have or have you ever had jaundice (yellow skin/eyes)? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you have or have you ever had a liver problem? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Is there a family history of liver problems (e.g. Wilson's disease, Primary biliary cholangitis, Primary sclerosing cholangitis, alpha 1 antitrypsin deficiency)? If yes, who and what?	<input type="checkbox"/> Yes <input type="checkbox"/> No

C. CANCER HISTORY

1.	Do you have or have you ever had cancer? If yes: Type? When? Treatment: <input type="checkbox"/> Radiation <input type="checkbox"/> Chemo <input type="checkbox"/> Surgery <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No **												
2.	Do you have a family history of cancer? <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Who</th> <th style="width: 45%;">Type of Cancer</th> <th style="width: 30%;">Did this Cause their Death?</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td> </td> <td> </td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td> </td> <td> </td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> </tbody> </table>	Who	Type of Cancer	Did this Cause their Death?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who	Type of Cancer	Did this Cause their Death?												
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown												
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown												
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown												

D. INFECTION RISKS

1.	Have you ever received a blood transfusion or other blood product (such as platelets, plasma)? If yes, type? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	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 **
3.	Have you ever been diagnosed with or treated for HIV, AIDS or any type of Hepatitis (e.g. Hepatitis B, Hepatitis C) or HTLV? If yes, what, when and treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No **

Name (First, Last) :

13. a) In the last 21 days, have you had sexual contact with a male who in the past 6 months has travelled or resided outside of Canada? Yes No
If yes, where did that person travel or reside? _____
If yes, when was your last sexual contact with this person? _____
 b) In the last 21 days, have you had sexual contact with a male who was diagnosed with Zika Virus within the last 6 months? Yes No
If yes, date of sexual contact? _____

14. Within the last **6 months** have you traveled to other parts of Canada, or anywhere outside of Canada (including the US)? If yes, please list: Yes No

Where? (City, Country)	When? (Specify Dates)

15. Have you ever lived outside of Canada for a period longer than 1 month? Yes No
If yes, where? **When?**

16. Have you ever been exposed to, diagnosed with, or suspected of having any travel related diseases (e.g. Malaria, Chagas, Babesiosis, Leishmaniasis)? Yes No
If yes, what and when?

17. Have you ever had a suspected or confirmed diagnosis of an emerging (developing) infectious disease? Yes No
If yes, what and when?

18. Have you ever received human growth hormone? Yes No
If yes, was it prior to 1986 within Canada or the US OR at any time outside Canada or the US? Yes No
**

19. Have you ever received dura mater (i.e. received a graft during neurosurgery)? Yes No
**

E. NEUROLOGICAL/PSYCHOLOGICAL

1. Do you have a seizure disorder/epilepsy? Yes No
If yes, please provide details:

2. Have you ever had a stroke/transient ischemic attack (TIA)? Yes No
If yes, when?

Name (First, Last) :		
3.	Have you and/or a family member been diagnosed with or been investigated for any degenerative neurological diseases such as dementia, Alzheimer's, brain tumours, Parkinson's disease, Lou Gehrig's (ALS) or Multiple Sclerosis)? If yes, who, what condition and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
4.	Have you and/or a family member been diagnosed with or been investigated for any prion-related disease (Creutzfeldt-Jakob disease (CJD), Gerstmann-Sträussler-Scheinker (GSS) or other variants)? If yes, who, what condition and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
5.	Have you been diagnosed or treated for meningitis or encephalitis of infectious or unknown etiology (cause)?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
6.	Have you ever had treatment for depression? If yes, when? What type of treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever had treatment for a psychiatric problem? If yes, what and when? What type of treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. CARDIOVASCULAR		
1.	Do you have or have you ever had heart disease or chest pain? If yes, provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you have or have you ever had high blood pressure? If yes, when and type of treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever had a heart attack? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have or 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
5.	Do you have or 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
G. HEMATOLOGY/BLOOD		
1.	Do you and/or a family member have or ever had hemophilia, anemia, sickle cell, thalassemia, or a clotting problem? If yes, who and what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever received human-derived clotting factor concentrates? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No **

Name (First, Last) :		
3.	Do you and/or a family member have or ever had a problem with excessive bleeding or any bleeding problems? If yes, who, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you had excessive bleeding with any surgery or dental extractions? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you and/or a family member ever had a blood clot in your lungs or legs? If yes, who and what? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. RESPIRATORY		
1.	Do you have or have you ever had any lung disease such as asthma, emphysema, or chronic obstructive pulmonary disease? If yes, what? When? Any treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever (check all that apply): <input type="checkbox"/> been tested for tuberculosis (TB), <input type="checkbox"/> been diagnosed with TB, <input type="checkbox"/> had a positive TB skin test, <input type="checkbox"/> received treatment for TB <input type="checkbox"/> been vaccinated against TB, or <input type="checkbox"/> exposed to someone with active TB? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you routinely use or have you ever used any inhalers or take medications to help your breathing? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have or have you ever had sleep apnea or used a CPAP machine? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. GASTROINTESTINAL		
1.	Do you have or have you ever had any digestive or intestinal problems (e.g. Crohn's, bloody stools, colitis)? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever had gallbladder problems or gallstones? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (First, Last):		
3.	<p>Have you ever had a colonoscopy or gastroscopy? If yes, what and when?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
J. GENITOURINARY		
1.	<p>Have you ever had problems with your kidneys (such as infections, disease, impaired kidney function, or stones)? If yes, what and when? </p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<p>Have you ever had any problems with your bladder (such as infections, incontinence or difficulty voiding)? If yes, please describe: When?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<p>a) Do you have or have you had any problems related to an enlarged prostate? If yes, what?</p> <p>b) Have you ever had a rectal prostate exam? If yes, when? Was it abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.....</p> <p>c) Have you ever had a prostate specific antigen (PSA) test? If yes, when? Was it abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.....</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
4.	<p>a) Date of Last Menstrual Period:</p> <p>b) Have you ever had a PAP smear? If yes, when:.....Was it abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.....</p> <p>c) Have you ever had a breast exam/mammogram? If yes, when:.....Was it abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.....</p>	<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

Name (First, Last):		
5.	Do you have or have you ever had a gynecologic problem? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
6.	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"/> NA
7.	Are you currently trying to become pregnant or do you have plans for future pregnancies? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
K. ENDOCRINE		
1.	Do you have diabetes? If yes: Type? Onset? Do you take medication? If yes, please indicate what type: <input type="checkbox"/> Oral <input type="checkbox"/> Injection Name: Have you ever injected Bovine insulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you have a family history of diabetes? If yes, who?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever had increased blood sugars (i.e., with pregnancy)? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever been diagnosed with thyroid disease? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
L. SOCIAL		
1.	Does your family have a history of any serious health issues? (i.e. heart disease, strokes, Creutzfeldt-Jakob (Mad Cow) disease), tuberculosis, kidney disease/stones)? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are you the sole wage earner in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	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)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (First, Last):

We are required to ask the following questions to meet **Health Canada 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.

4.	In the past 6 months, have you had a history of intranasal (snorting) cocaine use?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
5.	Have you been in a youth correctional facility, jail, or prison for more than 72 consecutive hours in the preceding 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
6.	In the past 12 months, have you had sex with any person whose medical, sexual, or social history you do not know well enough to accurately answer Questions 7 to 14	<input type="checkbox"/> Yes <input type="checkbox"/> No **
7.	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 (e.g. accidental needle stick), or through contact with an open wound, non-intact skin, or mucous membrane?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
8.	In the past 5 years have you 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**
9.	In the past 12 months, have you had sex with a person who used a needle to inject drugs into their veins, muscles, or under the skin, for non-medical use in the preceding 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
10.	In the past 5 years, have you ever had sex in exchange for money or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
11.	In the past 12 months, have you had a sexual partner who had sex in exchange for money or drugs in the preceding 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
12.	In the past 12 months, have you had sex with any person known or suspected to have HIV or clinically active hepatitis B or clinically active hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No**
13.	For Females only: In the past 12 months, have you had sex with a man who had sex with another man in the preceding 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No ** <input type="checkbox"/> NA
14.	For Males only: In the past 12 months, have you had sex with another man?	<input type="checkbox"/> Yes <input type="checkbox"/> No ** <input type="checkbox"/> NA

M. OTHER

1.	Is there any other information that we should know? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	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 ALL questions completely and to the best of my knowledge and ability.

Name of Potential Donor

Signature of Potential Donor

Date (dd/mmm/yyyy)

Name (First, Last):

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:

Email: livingdonorkidney@uhn.ca

Fax: 416-340-3009

Mail: 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. 7568

For potential **LIVER** Donors:

Email: livingdonorliver@uhn.ca

Fax: 416-340-4317

Mail: 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:

Email: eyetransplant@uhn.ca

Fax: 416-340-3319

Mail: 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. 8617

For potential **LUNG** Donors:

Email: Lungtxreferral@uhn.ca

Fax : 416-340-4044

Mail: Toronto General Hospital, University Health Network

585 University Avenue

Peter Munk Building

Transplant Assessment Center, Rm 100

Toronto, ON M5G 2N2

Tel: 416-340-4800 ext. 2252