

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: _____ Date Entered in Epic: _____
dd/mmm/yyyy dd/mmm/yyyy

Date ABO Received: _____ Date Reviewed: _____
dd/mmm/yyyy dd/mmm/yyyy

Donor: 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):
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Preferred Name (if applicable):	Preferred Pronoun: <i>(Please circle)</i> He / She / They / Ze / Zie / Xe / Sie / Hir / Ey / Open	Date of Birth: _____ / _____ / _____ yyyy mmm dd	Age:
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Provincial Health Card Number: <input type="checkbox"/> N/A	Health Insurance Card Expiry Date: <input type="checkbox"/> N/A _____ / _____ / _____ yyyy mmm dd
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Marital Status: <i>(Please Circle)</i> Married / Single / Divorced / Widowed / Common Law / Other:	Blood Type: A / B / AB / O Positive / Negative I have attached a copy of my blood type <input type="checkbox"/>
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Sex at birth: <i>(Please circle)</i> Male / Female	Height: _____ cm OR _____ ft _____ in	Weight: _____ kg OR _____ lbs	Office use only BMI:
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Gender: *(Please Circle)*
 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:
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Spoken language(s):	Preferred Language:
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Address: _____ <i>Street # and Name</i>	_____ <i>Apt #</i>	_____ <i>City</i>
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Province	Country	Postal Code	Email Address:
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Home Telephone:	Cell Telephone:	Work Telephone:
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How do you prefer to be contacted? Best time of day to contact: Morning or Afternoon	What is your Occupation? Can we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Family Doctor:	Family Doctor Telephone:
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Address: _____ <i>Street # and Name</i>	_____ <i>Unit #</i>	_____ <i>City</i>	_____ <i>Province</i>	_____ <i>Postal Code</i>
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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 (<i>someone you want to donate to</i>)? 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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Office use only: Recipient TGLN: _____ 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, nurse practitioner, family doctor or specialist for any ongoing health concerns? If yes , what:..... When:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No																		
2.	Have you ever had any major illnesses? If yes , What:..... When:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No																		
3.	Have you ever had any abdominal surgery? (gallbladder, appendix, bowel, etc.) If yes , What:..... 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; margin-top: 5px;"> <thead> <tr style="background-color: #e0e0e0;"> <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> </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 or any reactions to anesthetic? If yes , what?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																		

Name (First, Last) :

6. Do you routinely take any prescription medications, non-prescription medications including OTC (over the counter), or natural health products (e.g. herbals, vitamins), hormone replacement therapy or any other medications? If yes, please list:

Yes No

Name	Reason

7. Do you have any allergies (e.g. react to wasp/bee stings, food, medications, latex)?
If yes, please list below:

Yes No

Allergy	Symptom/Reaction

Yes No

If yes, do you carry an EpiPen?

8. Do you have or have you ever been diagnosed with any active or chronic infections (bacterial, viral, fungal) or been treated for any infections?

Yes No

If yes, what:.....
Treatment:.....

9. Have you ever: Been assessed for donation Donated a tissue or organ
 Received a tissue or organ transplant?
When:

Yes No

10. Do you currently use or have you used any tobacco products?
If yes, what: Smoke cigarettes, pipe, cigarillos, cigars or chew tobacco? **(check)**

Yes No

How many/often? per day week month year **(check one)**

When did you start?

If you have quit, when did you quit?

11. 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)?

Yes No

Since when?

Do you or any family member have a history of alcohol dependence?

Yes No

Who:

Have you ever had treatment for alcohol dependence?

Yes No

If yes, what treatment:.....

When:.....

Name (First, Last) :

12.	Do you currently use or have you used cannabis (marijuana)? If yes, method of use: <input type="checkbox"/> smoke, <input type="checkbox"/> oral, <input type="checkbox"/> sublingual, <input type="checkbox"/> topical, <input type="checkbox"/> other..... (check) How often? per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year (check one) When did you start? If you have quit, when did you quit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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13.	Have you ever been diagnosed or treated for an autoimmune disorder (e.g. Lupus, Crohn’s disease, rheumatoid arthritis, Cushing’s syndrome)? If yes, what? Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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
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2.	Do you have or have you ever had a liver problem? If yes, what: When:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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: What:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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 **
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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:40%;">Type of Cancer</th> <th style="width:35%;">Did this Cause their Death?</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown </td> </tr> <tr> <td> </td> <td> </td> <td align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown </td> </tr> <tr> <td> </td> <td> </td> <td 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 (e.g. platelets, plasma, fresh frozen plasma, fibrinogen)? If yes, type: When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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2.	Do you have or have you ever had any history of sexually transmitted infections (such as syphilis, herpes or gonorrhea)? If yes, what: When:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No **
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Name (First, Last) :		
3.	<p>a) In the last 12 months, have you had a tattoo, tattoo touch-up, permanent makeup/microblading, body modification, acupuncture or ear/body/face piercing?</p> <p>b) If yes, when:</p> <p>Name of Establishment?</p> <p>City</p> <p>c) If yes, do you know if the instruments and/or ink used were contaminated or shared or if non-sterile instruments were used (select one of the three below):</p> <p><input type="checkbox"/> Yes, they may have been contaminated, shared or non-sterile</p> <p><input type="checkbox"/> No, they were not contaminated, shared or non-sterile</p> <p><input type="checkbox"/> Not sure</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No ** <input type="checkbox"/> NA
4.	<p>Have you ever been diagnosed with or treated for: HIV, AIDS, HTLV or any type of Hepatitis (e.g. Hepatitis B, Hepatitis C)?</p> <p>If yes, what:.....</p> <p>When:.....</p> <p>Treatment:.....</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No **
5.	<p>Have you ever had a communicable disease (e.g. Tuberculosis, Mono, Ebola, H1N1, swine flu, measles, cold sores, COVID-19)?</p> <p>If yes, what:.....</p> <p>When:.....</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	<p>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?)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No **
7.	<p>In the past six months have you been bitten by an animal?</p> <p>If yes, please describe:</p> <p>.....</p> <p>Were you treated as if the animal was rabid or diagnosed with rabies?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No **
8.	<p>Have you been vaccinated for COVID-19?</p> <p>If yes, indicate the number of doses:.....</p> <p>When?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	<p>Have you had any recent injections or vaccinations (such as Influenza, Hepatitis (<i>Twinrix</i>), Shingles)?</p> <p>If yes, what vaccination?</p> <p>When?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	<p>Have you been vaccinated for Hepatitis B?</p> <p>If yes, when? <input type="checkbox"/> Date Unknown</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

Name (First, Last) :

11.	<p>Do you currently use or have you ever used, ingested, inhaled, injected (subcutaneous, intramuscular or intravenous) nonmedical or recreational drugs or other substances?</p> <p>If yes, what types: <input type="checkbox"/> Hash <input type="checkbox"/> LSD <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Crack <input type="checkbox"/> Crystal meth <input type="checkbox"/> Amphetamines (Bennies) <input type="checkbox"/> Stimulants (Uppers) <input type="checkbox"/> Benzodiazepines/Barbiturates (Downers) <input type="checkbox"/> Speed <input type="checkbox"/> Ecstasy <input type="checkbox"/> Anabolic steroids <input type="checkbox"/> Methadone <input type="checkbox"/> Other (please describe): </p> <p>If yes, what is your current consumption?</p> <p>If not current, what was your previous consumption?</p> <p>Have you ever had treatment for this? If yes, what treatment and when?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No														
12.	<p>Have you ever received human growth hormone?</p> <p>If yes, was it prior to 1986 within Canada or the US <u>OR</u> at any time outside Canada or the US?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No **														
13.	<p>Have you ever received dura mater (e.g. received a graft during neurosurgery)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No **														
14.	<p>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 past 56 days to areas where WNV is endemic (widely found)?</p> <p>If yes, please describe:.....</p> <p>When:.....</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No														
15.	<p>a) In the last 6 months, have you had an active Zika Infection?</p> <p>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?</p> <p>If yes, date of sexual contact?</p> <p>c) 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?</p> <p>If yes, where did that person travel or reside?.....</p> <p>If yes, when was your last sexual contact with this person?.....</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No														
16.	<p>Have you traveled to other parts of Canada or the US? If yes, please list:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr style="background-color: #cccccc;"> <th style="width: 50%; text-align: center;">Where? (City, Country)</th> <th style="width: 50%; text-align: center;">When? (Specify Dates)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Where? (City, Country)	When? (Specify Dates)													<input type="checkbox"/> Yes <input type="checkbox"/> No
Where? (City, Country)	When? (Specify Dates)															

Name (First, Last) :

17.	Have you traveled to anywhere outside of Canada? If yes, please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th style="width: 50%;">Where? (City, Country)</th> <th style="width: 50%;">When? (Specify Dates)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>			Where? (City, Country)	When? (Specify Dates)																				
Where? (City, Country)	When? (Specify Dates)																							

18.	Have you ever lived outside of Canada? If yes, where? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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19.	Have you ever been exposed to, diagnosed with, or suspected of having any travel related diseases (e.g. Malaria, Ebola, Chagas, Babesiosis, Strongyloides, Dengue, Leishmaniasis)? If yes, what: When:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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20.	Have you ever had a suspected or confirmed diagnosis of an emerging (developing) infectious disease? If yes, what: When:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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E. NEUROLOGICAL/PSYCHOLOGICAL

1.	Do you have a seizure disorder or epilepsy? If yes, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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2.	Have you ever had a stroke or transient ischemic attack (TIA)? If yes, what? When:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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3.	Have you and/or a family member been diagnosed with or been investigated for dementia or any degenerative neurological diseases such as Alzheimer’s, brain tumours, Parkinson’s disease, Lou Gehrig’s (ALS) or Multiple Sclerosis)? If yes, who: What: When:	<input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">**</p>
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Name (First, Last) :

4.	Have you and/or a family member been diagnosed with or been investigated for any prion-related disease (e.g. Creutzfeldt-Jakob disease (CJD), Bovine Spongiform Encephalopathy (BSE), Gerstmann-Sträussler-Scheinker (GSS) or other variants)? If yes, who: What: 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 psychiatric or emotional illness? If yes, what: when? What type of treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever seen or do you currently see a mental health professional? If yes, provide details: When:..... 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: When:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you have or have you ever had high blood pressure? If yes, when: 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, what? 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, what? 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: What:..... When:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Name (First, Last) :		
2.	Have you ever received human-derived clotting factor concentrates? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
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:..... 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: What:..... When:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. 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?	<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 <input type="checkbox"/> Exposed to someone with active TB? <input type="checkbox"/> lived or worked in an area with a high incidence of 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.	Have you ever had a colonoscopy or gastroscopy? If yes, what: When:	<input type="checkbox"/> Yes <input type="checkbox"/> No
J. GENITOURINARY		
1.	Have you ever had problems with your kidneys (such as infections, disease, impaired kidney function, or stones)? If yes, what: When:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	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
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"/> No <input type="checkbox"/> Yes 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"/> No <input type="checkbox"/> Yes 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) What is the date of your last menstrual period?</p> <p>b) Have you ever had a PAP smear? If yes, when:.....Was it abnormal? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe.....</p> <p>c) Have you ever had a breast exam? If yes, when:.....Was it abnormal? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe.....</p> <p>d) Have you ever had a mammogram? If yes, when:.....Was it abnormal? <input type="checkbox"/> No <input type="checkbox"/> Yes 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 <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, how many: 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 <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
J. 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 (e.g., 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: When:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
K. SOCIAL		
1.	Does your family have a history of any serious health issues? (e.g. heart disease, strokes, Creutzfeldt-Jakob disease (CJD), 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.	Do you have a main support person? If yes, who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have any children? If yes, how many:Ages:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (First, Last):

5.	Donating an organ or tissues requires approximately time off work to recover. Are able to take time off work? <ul style="list-style-type: none"> • 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
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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.

6.	In the past 6 months, do you have a history of intranasal drug use for non-medical reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
7.	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 **
8.	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 9 to 16?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
9.	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 **
10.	In the past 12 months 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**
11.	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 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
12.	In the past 12 months, have you ever had sex in exchange for money or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
13.	In the past 12 months, have you had a sexual partner who had sex in exchange for money or drugs in the preceding 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
14.	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**
15.	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
16.	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

L. 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

Name (First, Last):

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:
[Email: livingdonorkidney@uhn.ca](mailto: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](mailto: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](mailto: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](mailto: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