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 Epic: _____ *dd/mmm/yyyy*

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

Date Reviewed: _____ *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):

Preferred Name (if applicable):	Preferred Pronoun: *(Please circle)* He / She / They / Ze / Zie / Xe / Sie / Hir / Ey / Open	Date of Birth: _____ /_____/_____ yyyy mmm dd	Age:
Provincial Health Card Number: ☐ N/A		Health Insurance Card Expiry Date: ☐ N/A _____ /_____/_____ yyyy mmm dd	
Marital Status: *(Please Circle)* Married / Single / Divorced / Widowed / Common Law / Other:		Blood Type: A / B / AB / O Positive / Negative I have attached a copy of my blood type ☐	
Sex at birth: *(Please circle)* Male / Female	Height:_____ cm ***OR*** _____ft _____ in	Weight: _____ kg ***OR*** _____ lbs	***Office use only*** BMI:

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:

Spoken language(s):	Preferred Language:

Address: *Street # and Name* *Apt #* *City*

Province *Country* *Postal Code*	Email Address:

Home Telephone:	Cell Telephone:	Work Telephone:

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? ☐ Yes ☐ No

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: ***Recipient*** TGLN***:*** _____MRN: _____ ABO _____☐ N/A– Anonymous	
Have you discussed your wish to donate with the intended recipient?	☐ Yes ☐ No ☐ N/A
Have you expressed your interest in donation to your family/friends and are they supportive of this decision?	☐ 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.

	A. GENERAL HEALTH:	
1.	Do you see a nurse, nurse practitioner, family doctor or specialist for any ongoing health concerns? **If yes,** what:..... When:.....	☐ Yes ☐ No
2.	Have you ever had any major illnesses? **If yes,** What:..... When:.....	☐ Yes ☐ No
3.	Have you ever had any abdominal surgery? (gallbladder, appendix, bowel, etc.) **If yes,** What:..... When:.....	☐ Yes ☐ No
4.	Have you ever had any other surgeries or hospitalizations?	☐ Yes ☐ No
5.	Did you have any problems after surgery or any reactions to anesthetic? **If yes,** what?	☐ Yes ☐ No ☐ N/A

Year	Procedure/Reason	Name of Hospital

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: **Name** | **Reason** | | | | | | | | | | | | | | |	☐ Yes ☐ No
7.	Do you have any allergies (e.g. react to wasp/bee stings, food, medications, latex)? If yes, please list below: **Allergy** | **Symptom/Reaction** | | | | | | | | | | | | **If yes**, do you carry an EpiPen?	☐ Yes ☐ No ☐ Yes ☐ No
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? **If yes**, what:…… Treatment:……	☐ Yes ☐ No
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)** How many/often? …… per ☐day ☐week ☐month ☐year **(check one)** When did you start? …… If you have quit, when did you quit? ……	☐ Yes ☐ No
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)? …… Since when? …… Do you or any family member have a history of alcohol dependence? Who: …… Have you ever had treatment for alcohol dependence? **If yes,** what treatment:…… When:……	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Name (First, Last) :

12.	Do you currently use or have you used cannabis (marijuana)? **If yes,** method of use: ☐smoke, ☐oral, ☐sublingual, ☐topical, ☐other…… **(check)** How often? …… per ☐day ☐week ☐month ☐year **(check one)** When did you start? …….. If you have quit, when did you quit? ……	☐ Yes ☐ No
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: ……	☐ Yes ☐ No

B. LIVER HEALTH

1.	Do you have or have you ever had jaundice (yellow skin/eyes)? **If yes,** when? ……	☐ Yes ☐ No
2.	Do you have or have you ever had a liver problem? **If yes,** what:…… When: ……	☐ Yes ☐ 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:…… What: ……	☐ Yes ☐ No

C. CANCER HISTORY

1.	Do you have or have you ever had cancer? **If yes:** Type:…… When:…… Treatment: ☐Radiation ☐Chemo ☐Surgery ☐Other: ……	☐ Yes ☐ No **
2.	Do you have a family history of cancer?	☐ Yes ☐ No

Who	Type of Cancer	Did this Cause their Death?
		□ Yes □ No □ Unknown
		□ Yes □ No □ Unknown
		□ Yes □ No □ 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? ……	☐ Yes ☐ No
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:……	☐ Yes ☐ No **

Name (First, Last) :		
3.	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? b) **If yes,** when: …… Name of Establishment? …… City …… 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): ☐ Yes, they may have been contaminated, shared or non-sterile ☐ No, they were not contaminated, shared or non-sterile ☐ Not sure	☐ Yes ☐ No ** ☐ NA
4.	Have you ever been diagnosed with or treated for: HIV, AIDS, HTLV or any type of Hepatitis (e.g. Hepatitis B, Hepatitis C)? **If yes,** what:…… When:…… Treatment:……	☐ Yes ☐ No **
5.	Have you ever had a communicable disease (e.g. Tuberculosis, Mono, Ebola, H1N1, swine flu, measles, cold sores, COVID-19)? **If yes,** what:…… When:……	☐ Yes ☐ No
6.	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 **
7.	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 **
8.	Have you been vaccinated for COVID-19? **If yes**, indicate the number of doses:…… When? ……	☐ Yes ☐ No
9.	Have you had any recent injections or vaccinations (such as Influenza, Hepatitis (*Twinrix*), Shingles)? **If yes,** what vaccination? …… When? ……	☐ Yes ☐ No
10.	Have you been vaccinated for Hepatitis B? **If yes,** when? …… ☐ Date Unknown	☐ Yes ☐ No ☐ Not Sure

Name (First, Last) :

11.	Do you currently use or have you ever used, ingested, inhaled, injected (subcutaneous, intramuscular or intravenous) nonmedical or recreational drugs or other substances? **If yes,** what types: □Hash □LSD □Cocaine □Heroin □Crack □Crystal meth □Amphetamines (Bennies) □Stimulants (Uppers) □ Benzodiazepines/Barbiturates (Downers) □Speed □Ecstasy □Anabolic steroids □Methadone □Other (please describe): ..... **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
12.	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 **
13.	Have you ever received dura mater (e.g. received a graft during neurosurgery)?	☐ Yes ☐ No **
14.	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)? **If yes,** please describe:..... When:.....	☐ Yes ☐ No
15.	a) In the last 6 months, have you had an active Zika Infection? 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? **If yes**, date of sexual contact? ..... 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? **If yes**, where did that person travel or reside?..... **If yes**, when was your last sexual contact with this person?.....	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
16.	Have you traveled to other parts of Canada or the US? If yes, please list:	☐ Yes ☐ No

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

Name (First, Last) :

17.	Have you traveled to anywhere outside of Canada? If yes, please list: **Where? (City, Country)** / **When? (Specify Dates)** ( ) / ( ) ( ) / ( ) ( ) / ( ) ( ) / ( ) ( ) / ( ) ( ) / ( ) ( ) / ( ) ( ) / ( ) ( ) / ( )	☐ Yes ☐ No
18.	Have you ever lived outside of Canada? **If yes,** where? …… When? ……	☐ Yes ☐ No
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:……	☐ Yes ☐ No
20.	Have you ever had a suspected or confirmed diagnosis of an emerging (developing) infectious disease? **If yes,** what:…… When:……	☐ Yes ☐ No
E. NEUROLOGICAL/PSYCHOLOGICAL		
1.	Do you have a seizure disorder or epilepsy? **If yes**, please provide details: ……	☐ Yes ☐ No
2.	Have you ever had a stroke or transient ischemic attack (TIA)? **If yes,** what? …… When**:** ……	☐ Yes ☐ No
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:……	☐ Yes ☐ No **

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:.....	☐ Yes ☐ No **
5.	Have you been diagnosed or treated for meningitis or encephalitis of infectious or unknown etiology (cause)?	☐ Yes ☐ No **
6.	Have you ever had treatment for psychiatric or emotional illness? **If yes,** what: ..... when? ..... What type of treatment?	☐ Yes ☐ No
7.	Have you ever seen or do you currently see a mental health professional? **If yes,** provide details:..... When:..... Treatment:.....	☐ Yes ☐ No
F. CARDIOVASCULAR		
1.	Do you have or have you ever had heart disease or chest pain? **If yes,** provide details:..... When:	☐ Yes ☐ No
2.	Do you have or have you ever had high blood pressure? **If yes,** when: ..... Type of treatment:	☐ Yes ☐ No
3.	Have you ever had a heart attack? **If yes,** when?	☐ Yes ☐ No
4.	Do you have or have you ever had rheumatic fever, or been told you have a heart murmur? **If yes,** what? ..... When:	☐ Yes ☐ No
5.	Do you have or have you ever had palpitations or been told that you have a heart arrhythmia? **If yes,** what? ..... When:	☐ Yes ☐ 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:.....	☐ Yes ☐ No

Name (First, Last) :

2.	Have you ever received human-derived clotting factor concentrates? **If yes,** when?	☐ Yes ☐ 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:.....	☐ Yes ☐ No
4.	Have you had excessive bleeding with any surgery or dental extractions? **If yes,** when?	☐ Yes ☐ No
5.	Have you and/or a family member ever had a blood clot in your lungs or legs? **If yes,** who:..... What:..... When:.....	☐ Yes ☐ 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? ..... Any treatment?.....	☐ Yes ☐ No
2.	Have you ever (check all that apply): □Been tested for tuberculosis (TB) □Been diagnosed with TB, □Had a positive TB skin test □Received treatment for TB □Been vaccinated against TB □Exposed to someone with active TB? □lived or worked in an area with a high incidence of TB **If yes,** when?	☐ Yes ☐ No
3.	Do you routinely use or have you ever used any inhalers or take medications to help your breathing? **If yes,** what?	☐ Yes ☐ No
4.	Do you have or have you ever had sleep apnea or used a CPAP machine? **If yes,** please describe:.....	☐ Yes ☐ 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?	☐ Yes ☐ No
2.	Have you ever had gallbladder problems or gallstones? **If yes,** when?	☐ Yes ☐ No

Name (First, Last):		
3.	Have you ever had a colonoscopy or gastroscopy? **If yes,** what:…… When:……	☐ Yes ☐ 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:……	☐ Yes ☐ No
2.	Have you ever had any problems with your bladder (such as infections, incontinence or difficulty voiding)? **If yes,** please describe: …… When? ……	☐ Yes ☐ No
3.	a) Do you have or have you had any problems related to an enlarged prostate? **If yes,** what? …… b) Have you ever had a rectal prostate exam? **If yes,** when? …… Was it abnormal? ☐ No ☐ Yes **If yes,** please describe…… c) Have you ever had a prostate specific antigen (PSA) test? **If yes,** when? …… Was it abnormal? ☐ No ☐ Yes **If yes,** please describe……	☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA
4.	a) What is the date of your last menstrual period? …….. b) Have you ever had a PAP smear? **If yes**, when:……Was it abnormal? ☐ No ☐ Yes **If yes,** please describe…… c) Have you ever had a breast exam? **If yes**, when:……Was it abnormal? ☐ No ☐ Yes **If yes,** please describe…… d) Have you ever had a mammogram? **If yes,** when:……Was it abnormal? ☐ No ☐ Yes **If yes,** please describe……	☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA

Name (First, Last):		
5.	Do you have or have you ever had a gynecologic problem? **If yes,** what?……	☐ Yes ☐ No ☐ 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? ……	☐ Yes ☐ No☐ ☐NA ☐ Yes ☐ No ☐NA
7.	Are you currently trying to become pregnant or do you have plans for future pregnancies? **If yes,** when? ……	☐ Yes ☐ No ☐ NA
J. ENDOCRINE		
1.	Do you have diabetes? **If yes**: Type? …… Onset? …… Do you take medication? **If yes, please indicate what type:** ☐ Oral ☐ Injection Name: …… Have you ever injected Bovine insulin?	☐ Yes ☐ No ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No
2.	Do you have a family history of diabetes? **If yes,** who? ……	☐ Yes ☐ No
3.	Have you ever had increased blood sugars (e.g., with pregnancy)? **If yes,** please describe: ……	☐ Yes ☐ No
4.	Have you ever been diagnosed with thyroid disease? **If yes,** what: …… When:……	☐ Yes ☐ 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: …… ……	☐ Yes ☐ No
2.	Are you the sole wage earner in your household?	☐ Yes ☐ No
3.	Do you have a main support person? **If yes**, who:……	☐ Yes ☐ No
4.	Do you have any children? **If yes,** how many:……Ages:……	☐ Yes ☐ No

Name (First, Last):		
5.	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 **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?	□ Yes □ No **
7.	Have you been in a youth correctional facility, jail, or prison for more than 72 consecutive hours in the preceding 12 months?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ No **
12.	In the past 12 months, have you ever had sex in exchange for money or drugs?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ No ** □ NA
16.	**For Males only:** In the past 12 months, have you had sex with another man?	□ Yes □ No ** □ NA
L. OTHER		
1.	Is there any other information that we should know? **If yes,** what? …… ……	☐ Yes ☐ 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.**	☐ Yes ☐ 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 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