UHN Ajmera Transplant Centre

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 _____ (□ 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: *(Please circle)* He / She / They / Ze / Zie / Xe / Sie / Hir / Ey / Open	Date of Birth: _____ /_____/_____ dd mmm yyyy	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 / 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*

City *Province* *Country* *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*

UHN Ajmera Transplant Centre

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 ☐ 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, family doctor or specialist for any ongoing health concerns? **If yes,** what and when? ……	☐ Yes ☐ No
2.	Have you ever had any major illnesses? **If yes,** what and when? ……	☐ Yes ☐ No
3.	Have you ever had any abdominal surgery? (gallbladder, appendix, bowel, etc.) **If yes,** what type, when? ……	☐ Yes ☐ No
4.	Have you ever had any other surgeries or hospitalizations?	☐ Yes ☐ No
5.	Did you have any problems after surgery/anesthetic? **If yes,** what were the problems? ……	☐ 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), or any other medications? If yes, please list: **Name** | **Reason** | | | | | | | | | | | |	☐ Yes ☐ No
7.	Do you have any allergies (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 or had any active or chronic infections (bacterial, viral, fungal) or been treated for any infections? **If yes**, what and specify any treatment: ……	☐ Yes ☐ No
9.	Have you ever received a tissue or organ transplant? **If yes,** what and when? ……	☐ Yes ☐ No
10.	Do you currently smoke or have you ever smoked any tobacco products? **If yes,** what type: ☐cigarettes, ☐pipe, ☐cigarillos, ☐cigars? **(check one)** How many? …… 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 dependance? …… Have you ever had treatment for alcohol dependance? **If yes,** what treatment and when? ……	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
12.	Have you ever been diagnosed or treated for an autoimmune disorder (Lupus, Crohn's disease, rheumatoid arthritis)? **If yes,** what? …… Treatment: ……	☐ Yes ☐ No

Name (First, Last) :

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 and 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 and 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 (such as platelets, plasma)? **If yes,** type? …… When? ……	☐ Yes ☐ 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? ……	☐ Yes ☐ 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? …… ……	☐ Yes ☐ No **

Name (First, Last) :		
4.	Have you ever had a communicable disease (such as Tuberculosis, Mono, Ebola, H1N1, swine flu, measles, cold sores, COVID-19)? **If yes,** what and when? ……	☐ Yes ☐ No
5.	Do you have or have you ever had any history of sexually transmitted infections (such as syphilis, herpes or gonorrhea)? **If yes,** what and 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.	Do you currently use or have you ever used, ingested, inhaled, subcutaneous, intramuscular or intravenous nonmedical or recreational drugs? **If yes,** what types: □Marijuana/cannabis □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 ☐ Yes ☐ No **
9.	Have you been vaccinated for COVID-19? If yes, indicate dose, type and when? ……	☐ Yes ☐ No
10.	Have you had any recent vaccinations (such as Influenza, Hepatitis (*Twinrix*), Shingles)? **If yes,** what vaccination? …… When? ……	☐ Yes ☐ No
11.	Have you been vaccinated for Hepatitis B? **If yes,** when? …… ☐ Date Unknown	☐ Yes ☐ No ☐ Not Sure
12.	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,** what and when? ……	☐ Yes ☐ 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? **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? **If yes**, date of sexual contact? _____	☐ Yes ☐ No ☐ Yes ☐ No
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: **Where? (City, Country)** / **When? (Specify Dates)** _____ / _____ _____ / _____ _____ / _____ _____ / _____	☐ Yes ☐ No
15.	Have you ever lived outside of Canada for a period longer than 1 month? **If yes,** where? …… When? ……	☐ Yes ☐ No
16.	Have you ever been exposed to, diagnosed with, or suspected of having any travel related diseases (e.g. Malaria, Chagas, Babesiosis, Leishmaniasis)? **If yes,** what and when? ……	☐ Yes ☐ No
17.	Have you ever had a suspected or confirmed diagnosis of an emerging (developing) infectious disease? **If yes,** what and when? ……	☐ Yes ☐ No
18.	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 **
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? If yes, please provide details: ……	☐ Yes ☐ No
2.	Have you ever had a stroke/transient ischemic attack (TIA)? **If yes,** when? ……	☐ Yes ☐ No

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? ……	☐ Yes ☐ 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? ……	☐ 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 depression? **If yes, w**hen? …… What type of treatment? ……	☐ Yes ☐ No
7.	Have you ever had treatment for a psychiatric problem? **If yes,** what and when? …… What type of treatment? ……	☐ Yes ☐ No
F. CARDIOVASCULAR		
1.	Do you have or have you ever had heart disease or chest pain? **If yes,** provide details: ……	☐ Yes ☐ No
2.	Do you have or have you ever had high blood pressure? **If yes,** when and 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,** when? ……	☐ Yes ☐ No
5.	Do you have or have you ever had palpitations or been told that you have a heart arrhythmia? **If yes,** 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 and what? ……	☐ Yes ☐ No
2.	Have you ever received human-derived clotting factor concentrates? **If yes,** when? ……	☐ Yes ☐ 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? ……	☐ 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 and what? …… When? ……	☐ Yes ☐ 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? ……	☐ 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, or □exposed to someone with active 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 and 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 and 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? ☐ Yes ☐ No If yes, please describe…… c) Have you ever had a prostate specific antigen (PSA) test? **If yes**, when? …… Was it abnormal? ☐ Yes ☐ No If yes, please describe……	☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA
4.	a) Date of Last Menstrual Period: …….. b) Have you ever had a PAP smear? **If yes**, when:……Was it abnormal? ☐ Yes ☐ No If yes, please describe…… c) Have you ever had a breast exam/mammogram? **If yes**, when:……Was it abnormal? ☐ Yes ☐ No If yes, please describe……	☐ 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,** 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
7.	Are you currently trying to become pregnant or do you have plans for future pregnancies? **If yes,** when? …….	☐ Yes ☐ No ☐ NA
K. 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 (i.e., with pregnancy)? **If yes,** please describe: ……	☐ Yes ☐ No
4.	Have you ever been diagnosed with thyroid disease? **If yes,** what and when? ……	☐ Yes ☐ 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: ……	☐ Yes ☐ No
2.	Are you the sole wage earner in your household?	☐ Yes ☐ 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)	☐ Yes ☐ 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?	□ Yes □ No **
5.	Have you been in a youth correctional facility, jail, or prison for more than 72 consecutive hours in the preceding 12 months?	□ Yes □ 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	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ No **
10.	In the past 5 years, have you ever had sex in exchange for money or drugs?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ 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?	□ Yes □ No ** □ NA
14.	**For Males only:** In the past 12 months, have you had sex with another man?	□ Yes □ No ** □ NA
M. 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

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*)**

UHN Ajmera Transplant Centre

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