Dear Potential Living Kidney Donor,

Thank you for your interest in living kidney donation. Please read the information carefully to make an informed decision about whether living kidney donation is right for you. If you decide to proceed with the evaluation, please complete the following steps:

1. Communication- We request that you inform your recipient of your intention to donate. It is important to ensure their willingness to accept your gift.
2. Medical/Social/Travel (MST) Questionnaire- To ensure that this will be safe for both you and your recipient; we need to ask questions about your medical, social and travel history. Please answer the questions in the questionnaire that follows this letter to the best of your ability. The questionnaire is developed by The Kidney Paired Donation program, which is operated by Canadian Blood Services. Some of the questions are very personal but it is important that they are answered truthfully. Please be assured that all information is confidential and is used only to assess your suitability as a donor. Please complete the forms in ink. If a correction is necessary, just stroke out the error and initial above the area. Please do not use correction tape of any sort.
3. Consent Forms- Please read and sign the enclosed consent forms (Consent for Evaluation and Consent for Disclosure) with a witness. The witness can be anyone over the age of 18 and must sign that they have witnessed your signature on the same date.
4. Blood group- We require confirmation of your blood group with either a copy of your Canadian Blood Services card or report from your family physician. If you do not know your blood group, we will provide you with a requisition to verify.
5. After completing the questionnaire and signing the consent forms, you may return the signed documents to us via email: Livingkidneydonor@toh.ca, fax 613-738-8403 or via Canada Post to:
   Living Kidney Donor Program
   1967 Riverside Dr. - Box 643
   Ottawa, On. K1H 7W9
6. Donor Information Session- We offer monthly information sessions that are mandatory as part of your evaluations. You are welcome to attend at your convenience by calling 613-738-8400 ext 82719 to book.

We truly appreciate your interest in living kidney donation, and we would like to respect and support your decision whether or not you decide to proceed. Therefore, if we do not hear from you it will be assumed that you do not wish to proceed, and you will not be contacted.

Thank you,

The Ottawa Hospital Living Kidney Donor Program

613-738-8400 ext 82778

# KIDNEY DONOR EVALUATION CHECKLIST (PHASE 1)

| STEP | INSTRUCTIONS | COMPLETE |
|---|---|---|
| **STEP 1:**<br>Send the donor program your Medical/Social/ Travel (MST) questionnaire and signed consent forms | • The MST questionnaire requires your **signature on page 4 as well as a witness** (the witness cannot be your intended recipient). Please ensure the date you write is the same date your witness writes.<br>• Please ensure **both** consents are signed and the dates indicated, are the same for yourself and your witness.<br>• The questionnaire and consents can be e-mailed to: (Livingkidneydonor@toh.ca), faxed to: 613-738-8403 or mailed to: 1967 Riverside Dr. Box 643, Ottawa, ON, K1H 7W9. | ❑ |
| **STEP 2:**<br>Make an appointment with your Family Doctor (if you have one) | • Once your questionnaire and consents are received, we will send a form to your family doctor. The form asks them to complete an assessment and make sure your cancer screening is up to date. You may also need to complete a TB skin test.<br>• Your Family Doctor needs to fax us back the completed form to 613-738-8403 (The fax number is also on the form).<br>• If you do not have a Family Doctor please talk with the donor program, you may be able to complete some testing at a walk-in clinic. | ❑ |
| **STEP 3:**<br>Complete laboratory tests | • The donor program will mail or e-mail laboratory requisitions for you to complete. If they are e-mailed, you will need to fill in your personal information on the top right of the requisition (name, date of birth, address and health card number).<br>• You may complete these tests at any lab that is convenient: Lifelabs, Dynacare, BioTest, or an Ottawa Hospital lab (Civic, Riverside, or General).<br>• You must be fasting for 12 hours. Do not eat or drink anything **except water** for 12 hours before you go to the lab. | ❑ |
| **STEP 4:**<br>Attend virtual Living Donor Education session (Via MyChart on your phone or computer) | • Please call (613-738-800 ext. 82719 or e-mail (Livingkidneydonor@toh.ca) to sign up for an upcoming education session and obtain your activation code for MyChart (if not already active).<br>**** This can be scheduled before completing your laboratory tests (Step 3) if you like.*** | ❑ |
| **STEP 5:**<br>Call/ e-mail the donor program | • Call (613-738-8400 ext. 82719) or e-mail (Livingkidneydonor@toh.ca) the donor program once you have completed the laboratory tests, your family doctor has sent us back the form, and you have attended an education session. | ❑ |

# KPD Protocol: Potential Donor Disclosure & Medical & Social History Questionnaire

Dear Potential Donor:

The following Donor Disclosure and Questionnaire must be completed and returned to:

**Living Donation Program**

You are being asked to complete this questionnaire in order to comply with the Health Canada Regulations for organ and tissue donation and with your hospital program's standards. To ensure donation will be as safe as possible for both you and the person you will donate to, we need to ask questions about your current and past health. Many of the questions asked are similar to those asked when donating blood.

Please complete the form yourself and answer all of the questions to the best of your knowledge. If you are not able to complete the form yourself, the person who completes the form on your behalf should explain why in Question 72.

All information provided is private and confidential and is used only to assess your suitability as a potential living kidney donor.

If you have any questions or concerns, contact your Living Donation Program.

Yours sincerely,

Kidney Paired Donation Program


Adapted from original on-line publication in Transplantation at http://journals.lww.com/transplantjournal/Fulltext/2015/10001/Kidney_Paired_Donation_Protocol_for_Participating.1.aspx

## Potential Donor Demographic Information

<table>
<tr><td>For Office Use - Local Donor ID #:</td><td colspan="2">For Office Use - CTR Donor #:</td><td colspan="2"></td></tr>
<tr><td>First Name (Legal):</td><td colspan="2">Middle Name (Legal):</td><td colspan="2">Surname (Legal):</td></tr>
<tr><td colspan="2">Preferred Name:</td><td colspan="3">Birth date: ________ / _________/__________<br>yyyy mm dd</td></tr>
<tr><td colspan="4">Personal Health Insurance Number/Care Card Number:</td><td>Health Insurance Card Expiry Date:<br>______ / _______ / ______<br>yyyy mm dd</td></tr>
<tr><td colspan="5">Other health coverage plan:</td></tr>
<tr><td colspan="2">Height:</td><td colspan="3">Weight:</td></tr>
<tr><td colspan="2">For Office Use - BMI:</td><td colspan="3">ABO blood group, if known:</td></tr>
<tr><td colspan="2">Ethnic origin(s):</td><td colspan="3">Country of birth:</td></tr>
<tr><td colspan="2">Spoken language(s):</td><td colspan="3">Written language(s):</td></tr>
<tr><td colspan="5">Home (mailing) address:</td></tr>
<tr><td colspan="2">Home phone number:</td><td colspan="3">Cell phone number:</td></tr>
<tr><td colspan="2">Work phone number:</td><td colspan="3">Fax number:</td></tr>
<tr><td colspan="5">Email address:</td></tr>
<tr><td colspan="5">How do you prefer to be contacted?<br>______________________________<br>______________________________<br>______________________________</td></tr>
</table>

Family doctor's name: ____________________________________________

Address: ____________________________________________

Telephone: ______________________ Fax: ______________________

## Potential Donor Disclosure Form

### Compensation

In Canada, no monetary inducement, goods, or services of value shall be offered to a living donor, or any third party in exchange for organs.

(Source: CAN/CSA-Z900.1-17 Section 11 Compensation)

I, ____________________, have read the above statement(s).

I acknowledge and understand that the buying and selling of organs in _______________

and Canada is illegal. Only the reimbursement of legitimate expenses related to the donor evaluation and donation is acceptable.

I have not, and will not, accept money, gifts, and/or incentives in exchange for donating my kidney.

_________________________ _________________________ _______ / ______ / _______

Print Name (Potential Donor) Signature Date yyyy mm dd

**Witness by:**

_________________________ _________________________ _______ / ______ / _______

Witness Name Witness Signature Date yyyy mm dd

Relationship of Witness (Witness CANNOT be inteded recipient)

**If Translator Used:**

_________________________ _________________________ _______ / ______ / _______

Translator Name Translator Signature Date yyyy mm dd

Relationship of Translator to Donor (Translator CANNOT be inteded recipient)


Adapted from original on-line publication in Transplantation at http://journals.lww.com/transplantjournal/Fulltext/2015/10001/Kidney_Paired_Donation_Protocol_for_Participating.1.aspx

**COMPLETE IN INK – Do not use pencil. Answer all questions.**

**You may provide additional comments for any question after Question 71.**
**Please list any questions that you did not understand or were unsure how to answer in question #71 at the end of the questionnaire. Your donor nurse coordinator will follow up with you.**

**General Questions About Donation**

1a Do you have an intended recipient (someone you want to donate to)? ❑ Yes ❑ No

1b **If Yes**, what is the recipient's name?

_______________________________________________

2 What is your relationship to the intended recipient? (Please be specific).

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

**Non-Directed Potential Donors Only (A non-directed donor is someone who does not know a person who needs a kidney transplant, but is willing to give a kidney to anyone in need)**

3 As a non-directed donor, what are your expectations about having contact with the recipient?

_______________________________________________

_______________________________________________

4 Would you want to have contact with the recipient? ❑ Yes ❑ No

**All Donors – Please Answer**

5 Have you told any of the following people that you wish to donate one of your kidneys?

| | | | |
|---|---|---|---|
| 5a. You intended recipient | ❑ Yes | ❑ No | ❑ Not Applicable |
| 5b. Your family or a friend(s | ❑ Yes | ❑ No | |
| 5c. Your family physician | ❑ Yes | ❑ No | |

6a Has anyone expressed any concerns about your plans to donate one your kidneys?

6b If Yes, please explain:

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

**All Donors – Please Answer**

7 Why do you wish to donate one of your kidneys?

________________________________________

________________________________________

________________________________________

________________________________________

8 How do you hear about Living Kidney Donation?

- ❑ Recipient
- ❑ Physician
- ❑ Patient Education Session
- ❑ Media (e.g., newspaper, radio)
- ❑ Website (which one?) ____________________________
- ❑ Other (please explain) ____________________________

9 What type of work do you do?

________________________________________

________________________________________

________________________________________

________________________________________

10 Organ donation is major surgery and requires approximately 6 to 8 weeks off work to recover. Do you think you will be able to take this amount of time off without affecting your position? ❑ Yes ❑ No

Additional Comments:

________________________________________

________________________________________

________________________________________

________________________________________

11 Would you accept blood products. ❑ Yes ❑ No

12 Do you have a partner or main support person? ❑ Yes ❑ No

12b **If Yes**, what is your relationship to that person?

________________________________________

________________________________________

________________________________________

________________________________________

## Questions About Year Health

13a Have you ever been assessed for living cell/organ/tissue donation? ❑ Yes ❑ No
13b If Yes, when and where were you assessed?

Date: ________ / ________/ ________ Place ______________________________
yyyy mm dd

14a If Yes to Question 13a, did you ever donate cells/organs/tissues? ❑ Yes ❑ No

14b **If Yes**, what did you donate? ______________________________

14c **If No**, why did you not donate? ______________________________

15a Have you ever been refused as a blood donor or have you been asked not to donate blood? ❑ Yes ❑ No
15b **If Yes**, why?

______________________________

15c **If Yes**, when did this happen? ______________________________

16 Do you consider yourself to be in: ❑ Excellent Health ❑ Good Health ❑ Poor Health
17 Can you walk up 2 flights of stairs without chest pain or shortness of breath? ❑ Yes ❑ No
18 Are you physically active? ❑ Yes ❑ No
19 Explain what physical activities you do:

______________________________

______________________________

______________________________

20a Do you see a nurse, family doctor, or a specialist for any ongoing health concerns? ❑ Yes ❑ No
20b If Yes, please provide details:

Name of the nurse, doctor, or specialist: ______________________________

Reason for the visits: ______________________________

Date of last visit or contact:__________ / __________ / __________
yyyy mm dd

21 Have you ever had any major illnesses? ❑ Yes ❑ No
22 Have you ever been admitted to a hospital? ❑ Yes ❑ No
23 Have you ever had any operations or surgical procedures? ❑ Yes ❑ No
24 If you answered “Yes” to Question 21, 22, and/or 23, please provide details (date, illness, reason for admission, name of doctor/specialist, hospital):

______________________________

______________________________

______________________________

______________________________

25a Do you take any medications (including prescription and non-prescription medications, over-the-counter medications, hormone replacement therapy and/or herbal remedies)? ❑ Yes ❑ No

25b **If Yes**, please list all the medications and remedies you take/use and state the reasons for taking/using them:

| Name of Medication | Reason for taking medication |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

26a Have you ever used alternative medical treatments (e.g., acupuncture)? ❑ Yes ❑ No

26b **If Yes**, what were these and why did you use them, when did you use them, and for how long?

________________________________________

________________________________________

________________________________________

27a Do you have any allergies (e.g., react to bee/wasp stings, peanuts, shellfish, medications, latex, etc.)? ❑ Yes ❑ No

27b **If Yes**, what are you allergic to, and explain what happens when you have a reaction? (e.g., anaphylaxis, life-threatening breathing problems, rash, etc.)

________________________________________

________________________________________

28a Have you ever had a reaction to anesthesia? ❑ Yes ❑ No

28b **If Yes**, what was the reaction and how was it treated?

________________________________________

________________________________________

29a Do you have any active infections (bacterial, viral, or fungal)? ❑ Yes ❑ No

29b **If Yes**, what are the infections and how are they being treated?

________________________________________

________________________________________

| 30 | Have you ever been diagnosed or treated for any of the following? | If you answer Yes to any of the questions under #30 or are unsure how to answer, please provide more details |
|---|---|---|
| a. | Heart disease or chest pain | ❑ Yes ❑ No ________________ |
| b. | Stroke | ❑ Yes ❑ No ________________ |
| c. | High Blood Pressure | ❑ Yes ❑ No ________________ |
| d. | Diabetes | ❑ Yes ❑ No ________________ |
| e. | Kidney stones | ❑ Yes ❑ No ________________ |
| f. | Kidney disease | ❑ Yes ❑ No ________________ |
| g. | Bladder or kidney infection | ❑ Yes ❑ No ________________ |
| h. | Thyroid disease | ❑ Yes ❑ No ________________ |
| i. | Bleeding problems, blood clots | ❑ Yes ❑ No ________________ |
| j. | Lung disease (e.g., asthma, sleep apnea, emphysema, chronic obstructive pulmonary disease [COPD]) | ❑ Yes ❑ No ________________ |
| k. | Cancer (e.g., skin cancer, leukemia, lymphoma, or any other cancer) | ❑ Yes ❑ No ________________ |
| l. | Stomach/bowel disorder (e.g., Crohn's disease, bloody stools, ulcerative colitis) | ❑ Yes ❑ No ________________ |
| m. | Liver disease | ❑ Yes ❑ No ________________ |
| n. | Hepatitis | ❑ Yes ❑ No ________________ |
| o. | HIV or AIDS or HTLV | ❑ Yes ❑ No ________________ |
| p. | Dementia or neurological disorder (e.g., Parkinson's disease, ALS [Lou Gehrig's disease], epilepsy, brain tumour) | ❑ Yes ❑ No ________________ |
| q. | Meningitis or encephalitis | ❑ Yes ❑ No ________________ |

| | | |
|---|---|---|
| r. | Autoimmune disorder (e.g., lupus, Crohn's disease, rheumatoid arthritis, Cushing syndrome) | ❑ Yes ❑ No ____________ |
| s. | Creutzfeldt-Jakob disease (CJD or mad cow disease) or any prion-related disease | ❑ Yes ❑ No ____________ |
| t. | Communicable disease(s) — viral, bacterial, or fungal (e.g., H1N1, swine flu, measles, cold sores) | ❑ Yes ❑ No ____________ |
| u. | Sexually transmitted infection(s) (e.g., syphilis, herpes, gonorrhea) | ❑ Yes ❑ No ____________ |
| v. | Any suspected or confirmed diagnosis of an emerging (developing) infectious disease | ❑ Yes ❑ No ____________ |
| w. | An animal bite in the past 6 months (e.g., bat, skunk, dog, or other animal)<br>**If Yes**, what type of animal bit you and were you treated as if the animal was suspected of carrying rabies? | ❑ Yes ❑ No ____________ |
| x. | Please provide additional information about any other health conditions or illnesses you have been treated for: ____________ | |

31a Have you been vaccinated or received an injection (needle) for any reason in the last 8 weeks? ❑ Yes ❑ No

31b If Yes, what was the vaccination or injection, and why did you get it?

______________________________________________

______________________________________________

32 Tuberculosis (TB)

Have you ever:

a. been tested for TB? ❑ Yes ❑ No

b. been diagnosed with TB? ❑ Yes ❑ No

c. had a positive TB skin test? ❑ Yes ❑ No

d. received treatment for TB? ❑ Yes ❑ No

e. been vaccinated for TB? ❑ Yes ❑ No

f. been exposed to someone with active TB? ❑ Yes ❑ No

g. worked on a First Nations reserve? ❑ Yes ❑ No

h. **If you answered "Yes"** to any question about TB or are unsure how to answer a question, please provide details:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

33 Have you ever had a psychiatric or emotional illness? ❑ Yes ❑ No

34 Have you ever seen a mental health professional, or are you currently seeing a mental health professional? ❑ Yes ❑ No

35 In the past 5 years, have you been prescribed antidepressants, anti-anxiety medications, pain medications, uppers/downers, or other similar medications? ❑ Yes ❑ No

36 If you answered "Yes" to Question 33, 34, and/or 35, please provide details:

______________________________________________

______________________________________________

______________________________________________

| 37 | Have you ever received any of the following? | If Yes to any question under #37, please state when and in what country. |
|---|---|---|
| a. | Human growth hormone injections | ❑ Yes ❑ No ❑ Unsure<br>If Yes, when and where?<br>____________________________________ |
| b. | An organ or tissue transplant (e.g., bone, cornea, skin) | ❑ Yes ❑ No ❑ Unsure<br>If Yes, when and where?<br>____________________________________ |
| c. | A graft or transplant of dura mater (brain/spinal tissue) | ❑ Yes ❑ No ❑ Unsure<br>If Yes, when and where?<br>____________________________________ |
| d. | Injected bovine insulin (since 1980) | ❑ Yes ❑ No ❑ Unsure<br>If Yes, when and where?<br>____________________________________ |
| e. | A blood transfusion or other blood product(s) ( e.g., platelets, fresh frozen plasma, fibrinogen, etc.), or IV [intravenous] infusions | ❑ Yes ❑ No ❑ Unsure<br>If Yes, when and where?<br>____________________________________ |
| f. | If Yes, did you receive any of these products in the United Kingdom/ Europe or Africa since 1980? | ❑ Yes ❑ No ❑ Unsure<br>If Yes, when and where?<br>____________________________________ |

## For Females Only (Biological Sex at Birth): ❑ Not Applicable

38a Do you get regular Pap tests? ❑ Yes ❑ No

38b **If Yes**, when was your last Pap test? *(yyyy/mm)* ____________

38c Have you ever had an abnormal Pap test? ❑ Yes ❑ No

38d If Yes, please explain: ______________________________________________

______________________________________________________________________

39a Have you ever had a mammogram? ❑ Yes ❑ No

39b **If Yes**, when was your last mammogram? *(yyyy/mm)* _________

39c **If Yes**, have you ever had an abnormal mammogram? ❑ Yes ❑ No

39d **If Yes**, please explain: ______________________________________________

______________________________________________________________________

40a Have you ever had any pregnancies? ❑ Yes ❑ No

40b **If Yes**, to Question 40a, how many: Pregnancies ____ Miscarriages___ Abortions ___

40c **If Yes**, to Question 40a, were you ever diagnosed with gestational diabetes? (became diabetic during pregnancy)? ❑ Yes ❑ No

40d **If Yes**, to Question 40c, describe any treatment

______________________________________________________________________

______________________________________________________________________

40e **If Yes**, to Question 40a, did you ever have high blood pressure during pregnancy? ❑ Yes ❑ No

40f If Yes, to Question 40e, describe any treatment

______________________________________________________________________

______________________________________________________________________

41a Are you currently pregnant or trying to become pregnant? ❑ Yes ❑ No

41b **If No**, do you have any plans for future pregnancies? ❑ Yes ❑ No

41c. **If Yes**, please tell us more about your future plans/ timing for pregnancy.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**For Males Only (Biological Sex at Birth): ❑ Not Applicable**

42a Have you ever had a rectal prostate exam? ❑ Yes ❑ No

42b If Yes, when was your last prostate exam? (yyyy/mm) ___________________

43a Have you ever had a prostate-specific antigen (PSA) blood test? ❑ Yes ❑ No

43b If Yes, when was your last PSA blood test? (yyyy/mm) __________________

44a If yes to 42 a or 43 a, have you ever had an abnormal prostate exam or PSA result? ❑ Yes ❑ No

44b **If Yes**, please provide details

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**All Donors - Questions About Your Personal History**

***As mentioned, the next section contains some questions that are sensitive and personal in nature. Our program would like to remind you that we are required by law to ask these questions about all potential donors.***

45a Do you currently smoke? ❑ Yes ❑ No

45b **If Yes**, how long have you smoked? _______ How much do you smoke? ___________

45c **If No**, did you smoke in the past? ❑ Yes ❑ No

45d If you smoked in the past, how much did you smoke? __________________________

45e If you smoked in the past, for how long did you smoke? ________________________

45f If you smoked in the past, when did you stop smoking? _________________________

46a Do you currently drink alcohol? ❑ Yes ❑ No

46b **If Yes**, how often? ______________________ How much do you drink? __________

46c **If No**, did you drink alcohol in the past? ❑ Yes ❑ No

46d If you drank alcohol in the past, how much did you drink? _______________________

46e If you drank alcohol in the past, for how long did you drink? ______________________

46f If you drank alcohol in the past, when did you stop drinking? _____________________

47a Have you ever used non-prescription street drugs? (e.g., heroin, cocaine, crack, LSD, crystal meth, bennies, uppers, downers, marijuana, hashish, speed, ecstasy, or anabolic steroids) ❑ Yes ❑ No

47b **If Yes**, what drug(s) and for how long did you use it/them?

________________________________________________________________________

47c **If Yes**, in the past 6 months have you used intranasal (snorted) cocaine? ❑ Yes ❑ No

48a **In the past 5 years**, have you ever used a needle to inject drugs into your vein(s), into a muscle, or under your skin for non-medical use? ❑ Yes ❑ No

48b **In the past 12 months**, have you had sex with a person who has used a needle to inject drugs into his/her vein(s), into a muscle, or under the skin, for non-medical use? ❑ Yes ❑ No ❑ Unsure

| | | |
|---|---|---|
| 49 | **In the past 5 years**, have you ever exchanged sex for money or drugs? | ❑ Yes ❑ No |
| 50 | **In the past 12 months**, have you had sex with a person who has exchanged sex for money or drugs? | ❑ Yes ❑ No ❑ Unsure |
| 51a | **In the past 21 days**, have you had sexual contact with a man who is known to have had a medical diagnosis of Zika virus infection within six months prior to the sexual contact. | ❑ Yes ❑ No ❑ Unsure |
| | 51b **In the past 21 days**, have you had sexual contact with a man who resided in, or travelled to an area with active Zika virus transmission within the past six months? | ❑ Yes ❑ No ❑ Unsure |
| 52 | **In the past 12 months**, have you had sex with anyone known to have, or suspected to have, HIV or AIDS, clinically active (symptoms of) hepatitis B or clinically active (symptoms of) hepatitis C, or HTLV? | ❑ Yes ❑ No ❑ Unsure |
| **53a** | Have you ever had sex with anyone who was born in, or lived in, Central Africa or West Africa? | ❑ Yes ❑ No ❑ Unsure |
| | 53b **If Yes**, when did this occur? (yyyy/mm) ______________ | |
| 54 | **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 48b to 53a? | ❑ Yes ❑ No |
| 55 | **In the past 12 months**, have you been in a jail, prison, or youth correctional facility for more than 72 consecutive hours? | ❑ Yes ❑ No |
| 56 | **In the past 12 months**, have you been exposed to blood from a person, known or suspected to have hepatitis B, hepatitis C, and/or HIV or AIDS, through an accidental needle stick or through contact with an open wound, saliva, non-intact skin, or mucous membrane? | ❑ Yes ❑ No |
| 57 | **In the past 12 months**, have you had close contact (e.g., who lives in the same household and shares kitchen and bathroom facilities with you) with a person who has clinically active (symptoms of) hepatitis B or C, or yellow jaundice? | ❑ Yes ❑ No |
| 58a | In the past 12 months, have you had a tattoo, tattoo touch-up, permanent makeup/microblading, body modification, acupuncture or an ear/body/face piercing? | ❑ Yes ❑ No |
| | 58b If Yes, name of establishment:________________City: ____________________________<br>Procedure: ______________________________________________________________________ | |
| | 58c If Yes, do you know if the instruments and/or ink used were contaminated or shared, or if non-sterile instruments were used? ❑ Yes, they may have been contaminated, shared or non-sterile<br>❑ No, they were not contaminated, shared or non-sterile<br>❑ Not sure | |
| 59 | *For Females Only*: **In the past 12 months**, have you had sex with a man who had sex with another man within the previous 12 months? | ❑ Yes ❑ No ❑ Unsure |
| 60 | *For Males Only*: **In the past 12 months**, have you had sex, even one time, with a man? | ❑ Yes ❑ No ❑ Unsure |

## Questions About Your Travel History

61 Have you ever lived outside of Canada for longer than 1 month? ❑ Yes ❑ No
62 In the **past 6 months**, have you travelled outside of Canada? ❑ Yes ❑ No
63 In the **past 6 months**, have you travelled within Canada? ❑ Yes ❑ No
64 **If you answered "Yes"** to Question 61, 62 and/or 63, state where you lived or travelled and when you returned (yyyy/mm).

______________________________________________
______________________________________________
______________________________________________
______________________________________________

65a Between 1980 and 1996, have you spent a total of 3 or more months outside of North America (e.g., Europe, Africa, Middle East)? ❑ Yes ❑ No

65b **If Yes**, where, when, and for how long?

______________________________________________
______________________________________________
______________________________________________
______________________________________________

| 66 Have you ever been exposed to, diagnosed with, or suspected of having, any of the following travel-related diseases? | If Yes to any question in #66, please provide more details: |
|---|---|
| a. West Nile Virus | ❑ Yes ❑ No ❑ Unsure ____________ |
| b. Malaria (or taken anti-malarial medications) | ❑ Yes ❑ No ❑ Unsure ____________ |
| c. Chagas disease (a parasitic insect disease) | ❑ Yes ❑ No ❑ Unsure ____________ |
| d. Babesiosis | ❑ Yes ❑ No ❑ Unsure ____________ |
| e. Leishmaniasis | ❑ Yes ❑ No ❑ Unsure ____________ |
| f. Zika Virus | ❑ Yes ❑ No ❑ Unsure ____________ |
| g. Did you exhibit any flu-like symptoms within 2 weeks of leaving a Zika virus risk area? | ❑ Yes ❑ No ____________ |
| h. Any other travel-related disease(s)? | ❑ Yes ❑ No ____________ |

## Questions About Your Family History

| | | |
|---|---|---|
| 67a | Do you have any children?<br>67b If Yes, how many? ____________________ Ages? ____________________________<br>67c Do any of them have any health concerns? (If Yes, see Question 69) | ❑ Yes ❑ No<br><br>❑ Yes ❑ No |
| 68a | Do you have any brothers and/or sisters?<br>68b If Yes, how many? ____________________ Ages? ____________________________<br>68c Do any of them have any health concerns? (If Yes, see Question 69) | ❑ Yes ❑ No<br><br>❑ Yes ❑ No |

| | | |
|---|---|---|
| 69 | Has anyone in your family been diagnosed with, or treated for, any of the following? | If you answer Yes to any question under Question 69, please provide more details, including which family member(s): |
| a. | Heart disease | ❑ Yes ❑ No ____________________________________ |
| b. | Diabetes | ❑ Yes ❑ No ____________________________________ |
| c. | Stroke | ❑ Yes ❑ No ____________________________________ |
| d. | Cancer | ❑ Yes ❑ No ____________________________________ |
| e. | Kidney disease / kidney stones | ❑ Yes ❑ No ____________________________________ |
| f. | Liver disease | ❑ Yes ❑ No ____________________________________ |
| g. | Bleeding problems | ❑ Yes ❑ No ____________________________________ |
| h. | Tuberculosis (TB) | ❑ Yes ❑ No ____________________________________ |
| i. | Creutzfeldt-Jakob Disease (CJD or mad cow disease) or any prion-related disease | ❑ Yes ❑ No ____________________________________ |
| j. | Any other major disease(s)? | ❑ Yes ❑ No ____________________________________<br>______________________________________________<br>______________________________________________<br>______________________________________________ |

| | | |
|---|---|---|
| 70a. | Is there any reason why you think you should not be an organ donor?<br>70b **If Yes**, <u>no explanation is required</u>. | ❑ Yes ❑ No |
| 71a. | Were there any questions on this form that you did not understand or were unsure of how to answer?<br>71b **If Yes**, which question(s)?<br>______________________________________________<br>______________________________________________<br>______________________________________________<br>______________________________________________<br>______________________________________________ | ❑ Yes ❑ No |

Add any additional information, questions, or comments you may have. If applicable, please indicate which question your comment refers to.:

______________________________________________________________________

______________________________________________________________________

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______________________________________________________________________

Potential donor: please sign this form here:

| Name of Potential Donor | Signature of Potential Donor | Date (yyyy/mm/dd) |
| --- | --- | --- |
| ______________________ | ______________________ | ______________ |

72 Was this Medical and Social History Questionnaire completed by a person other than the potential donor? ❑ Yes ❑ No

**If Yes**, why was it completed by another person?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

If Yes, designate of potential donor to sign form below:

| Print Name of Person Completing Form if not the Potential Donor | Signature of Person Completing Form if not the Potential Donor | Date (yyyy/mm/dd) |
| --- | --- | --- |
| ______________________ | ______________________ | ______________ |

**For Office Use Only:**

Comments/Follow-up:

© Canadian Blood Services

The Ottawa Hospital

- ☐ Civic
- ☐ General
- ☐ Riverside
- ☐ HI
- ☐ TRC
- ☐ TOHCC

# REQUEST/CONSENT FOR RELEASE/DISCLOSURE OF PATIENT HEALTH INFORMATION

health rec. no.

last name

first name

health insurance no. d.o.b. sex

How will the information be released? ☒ Paper copy ☐ CD ☐ Online

To: (Requester's address, phone number, and email address for Online Releases)

The Ottawa Hospital – Living Kidney Donor Program
Fax 613-738-8403

| INFORMATION | DATE RANGE FOR REPORTS / OTHER COMMENTS |
|---|---|
| ☐ Discharge Summary | |
| ☐ Operative Reports | |
| ☐ Pathology Reports | |
| ☐ Anaesthesia/Recovery Room | |
| ☐ Medical Imaging | |
| ☐ Report Only | |
| ☐ CD of Images | |
| ☐ Laboratory Reports | |
| ☐ Consultation/Progress Notes | |
| ☐ ER Record | |
| ☐ Chart Copy | |
| Details: | |
| ☐ Confirmation of Dates | |
| ☐ Proof of Death | |
| ☐ Family Health Team Reports | |
| ☒ Other: | Information pertaining to Living Kidney Donation |

Comments / Details:

PLEASE NOTE ALL FEES FOR RELEASE OF INFORMATION ARE NON-REFUNDABLE.

**CONSENT FOR RELEASE OF PATIENT HEALTH INFORMATION**

Patient consent must be obtained for disclosing personal health information to a third party (e.g.Lawyer, Ins Co.) or if the request is related to information from a health care organization located outside the province of Ontario.

I authorize The Ottawa Hospital to release/obtain the information noted above.

| Name of patient/substitute decision maker | Signature | Date (yyyy/mm/dd) |
|---|---|---|
| ✗ | ✗ | ✗ |
| Name of witness | Signature | Date (yyyy/mm/dd) |
| ✗ | ✗ | ✗ |

Authorization is valid for 1 year from date of signing. Include copies of documents providing your authority as a substitute decision-maker.

HEALTH RECORDS USE ONLY: Date received: TOTAL $: Received by:

# Consent to Living Kidney Pre-Donation Medical/Surgical Evaluation

I have read and understand the information provided, which includes:

i. The Ottawa Hospital Fact Sheet for Kidney Donor,
ii. Living Donor Paired Exchange Registry pamphlets,
iii. The Trillium Gift of Life Network Living Kidney Donor Information and/or Living Kidney Donation at The Ottawa Hospital booklet,
iv. The Program for Reimbursing Expenses of Living Organ Donors (PRELOD) booklet, if applicable,

**and**

I agree to proceed with a comprehensive evaluation process, to determine my candidacy as a living kidney donor.

I have been informed and understand that:

1 There is a risk the results of my evaluation may reveal a health problem, which could affect my insurability.

2 In Canada, no monetary inducement, goods, or services of value shall be offered to or accepted by a living donor, the donor's estate, or any other third party in exchange for cells, tissues, or organs.

3 I will be screened for the following infectious diseases: Hepatitis B and C, HIV (Human Immunodeficiency Virus), HTLV (Human T-Lymphotropic Virus) and Syphilis, and if positive, the Public Health Department is notified.

4 There will be out of pocket expenses including parking, travel and time away from work, beyond the reimbursement by PRELOD.

5 I may be found ineligible to donate my kidney.

6 During my evaluation, there is release of information to the transplant recipient team about my kidney vascular anatomy, blood type, tissue typing, and virology results. Any further release of information requires my notification and consent.

7 None of my health information is shared with the recipient unless I provide my written consent.

8 I may withdraw from the evaluation process, at any time, without penalty and that, the reason for withdrawal remains confidential.

| ______________________ | ______________________ | ______________ |
|---|---|---|
| Print Name of Potential Donor | Signature | Date |
| ______________________ | ______________________ | ______________ |
| Print Name of Witness (Status) | Signature (Status) | Date |
| ______________________ | ______________________ | ______________ |
| Print Name of Translator | Signature | Date |