For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

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 to comply with Health Canada Regulations for organ and tissue donation and with your hospital program's donor evaluation 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 67a.

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:

For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

Potential Donor Demographic Information

First Name (as written on your health card):	Middle Name: (as written on your health card):	Surname (as written on your health card):
Preferred Name:	Pronouns: (e.g., she/her, he/him, they/them)	Birth Date:_____ /_____/_____ yyy mm dd
Personal Health Insurance/Care Card Number:	Province of Residence:	Health Insurance Card Expiry Date (if applicable): _____ /_____/_____ yyy mm dd
If you have workplace or private insurance benefits or other health coverage plan, please provide information:		
Weight (kg):	Height (cm):	for Office Use - BMI:
ABO (blood group), if known:	Racial Identity:	Preferred Language:
Country of Birth:		Spoken / Written Language(s):
Home (mailing) Address:		
Home / Cell Phone Number:		Work Phone Number:
Email Address*:		
Preferred method of contact:	Email: ☐	Phone: ☐
Best time of day to contact:	Morning: ☐	Afternoon: ☐

** Email is not used for communication by all programs. Please check with your local program.*

Primary Care Provider Name: Address: Telephone: Fax:

For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

POTENTIAL DONOR DISCLOSURE FORM

Compensation (source: CAN/CSA-Z900.1 Section 11 Compensation)
In Canada, no monetary inducement, goods, or services of value shall be offered to a living donor, a deceased donor's next of kin, the donor's estate, or any other third party in exchange for CTOs (cells, tissues or organs).

I, _____, have read the above statement(s).
Print Name (Potential Donor)

I acknowledge and understand that the buying and selling of organs in all provinces and territories in Canada is illegal. Only the reimbursement of legitimate expenses related to the 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

Witnessed by:

_____	_____	_____ /_____/_____
Print Witness Name	Witness Signature	Date yyyy mm dd

Relationship of Witness *(Witness CANNOT be the intended recipient)* _____

If Translator Used:

_____	_____	_____ /_____/_____
Print Translator Name	Translators Signature	Date yyyy mm dd

Relationship of Translator to Donor *(Translator CANNOT be the intended recipient)* _____

For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

IF COMPLETING MANUALLY: COMPLETE IN INK (blue or black) - Do not use pencil. Answer all questions.

You may provide additional comments for any question in box #66 at the end of this document.
Please list any questions that you did not understand or were unsure how to answer in question #65. Your donor nurse coordinator will follow up with you.

General Questions About Donation

1 Do you have an intended transplant candidate? (Someone you want to donate to?) (**If No,** proceed to question 2) ☐ **Yes** ☐ **No**

1a. **If Yes,** what is the transplant candidate's name?

1b. **If Yes,** what is your relationship to your intended transplant candidate?

1c. Does the transplant candidate live in a different province than you? ☐ **Yes** ☐ **No**

1d. **If Yes**, what province do they live in?

1e. If your intended transplant candidate receives an organ from another donor, would you like us to contact you to share information about other potential opportunities for you to donate a kidney? ☐ **Yes** ☐ **No**

All Donors – Please Answer

2 Have you told any of the following people that you wish to donate one of your kidneys: *(check all that apply)*

Your transplant candidate ☐ **Yes** ☐ **No**

Your family or a friend(s) ☐ **Yes** ☐ **No**

Your primary care provider ☐ **Yes** ☐ **No**

3 Has anyone expressed any concerns about your plans to donate one of your kidneys? ☐ **Yes** ☐ **No**

3a. **If Yes,** please explain:

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

5 How did you hear about Living Kidney Donation?

Transplant Candidate ☐

Primary Care Provider ☐

Patient Education Session ☐

Media (e.g., newspaper, radio, Facebook, Instagram etc.?) (please list which one(s))

Website (which one?)

Other (please explain)

For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

All Donors – Please Answer

6 What type of work do you do?

7 Organ donation is a 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 work without affecting your position? ☐ **Yes** ☐ **No**

Additional comments:

8 If during your surgery or recovery from kidney donation, you needed blood products, would you agree to accept these? ☐ **Yes** ☐ **No**

9 Do you have a main support person? ☐ **Yes** ☐ **No**

9a. **If Yes,** what is your relationship to that person?

10 Are you the main support person for your household or family? ☐ **Yes** ☐ **No**

General Questions About Your Health

11 Have you ever been assessed for living cell/organ/tissue donation? ☐ **Yes** ☐ **No**

11a. **If Yes,** what, when and where were you assessed?

Date: ____ / ____ / ____ (*yyyy mm dd*) What: _____ Place: _____

11b. Have you donated living cells/organs/tissues? ☐ **Yes** ☐ **No**

11c. **If Yes,** where and what did you donate?

11d. **If No,** why did you not donate?

12 Have you ever been refused as a blood donor, or have you been asked not to donate blood? ☐ **Yes** ☐ **No**

12a. **If Yes,** why?

12b. **If Yes,** when did this happen? Date: ____ / ____ / ____ (*yyyy mm dd*)

13 Do you consider yourself to be in: ☐ **Excellent Health** ☐ **Good Health** ☐ **Poor Health**

14 Do you have chest pain or shortness of breath when you walk up 2 flights of stairs? ☐ **Yes** ☐ **No**

15 Are you physically active? ☐ **Yes** ☐ **No**

15a. **If Yes,** explain what physical activities you do?

For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

General Questions About Your Health

16 Do you see a primary care provider, or specialist for any ongoing health concerns? ☐ **Yes** ☐ **No**

16a. **If Yes,** please provide details:

Name of the primary care provider, or specialist:

Reasons for the visits:

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

17 Have you ever had any major illnesses? ☐ **Yes** ☐ **No**

18 Have you ever been admitted to a hospital? ☐ **Yes** ☐ **No**

19 Have you ever had any operations or surgical procedures? ☐ **Yes** ☐ **No**

If you answered **"Yes"** to Questions 17, 18, and/or 19, please provide details (date, illness or operation, reason for admission, name of primary care provider/specialist, hospital):

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General Questions About Your Health

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

20a. **If Yes,** please list all the medications and remedies you take/use and state the reason for taking/using them:

Name of medication and dose ,if applicable	**Frequency and reason for medication**

21. Have you taken any medication by mouth (oral) in the preceding 3 months to prevent HIV infection? ☐ **Yes** ☐ **No**

21a. Have you received any medication by injection in the preceding 2 years to prevent HIV infection? ☐ **Yes** ☐ **No**

22. Do you have any allergies (e.g., react to bee/wasp stings, peanuts, shellfish, medications, latex, etc.) ☐ **Yes** ☐ **No**

22a. **If Yes,** list what you are you allergic to, and explain what happens when you have a reaction: (e.g., anaphylaxis, life-threatening breathing problems, rash, etc.)

Allergy	**Reaction**

22b. Do you carry an EpiPen? ☐ **Yes** ☐ **No**

23 Have you ever had a reaction to anesthesia? ☐ **Yes** ☐ **No**

23a. **If Yes,** what was the reaction and how was it treated?

24 Do you have any active infections (bacterial, viral, or fungal)? ☐ **Yes** ☐ **No**

24a. **If Yes,** what are the infections and how are they being treated?

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General Questions About Your Health						
25	**Have you ever been diagnosed or treated for any of the following?**					**If you answer "Yes",** to any of the questions below, or are unsure how to answer, please provide more details:
	a. Heart disease, heart arrhythmia, 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**	

For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

General Questions About Your Health						
25 cont.	**Have you ever been diagnosed or treated for any of the following?**					**If you answer "Yes",** to any of these questions below or are unsure how to answer, please provide more details:
	o. HIV or AIDS or HTLV	☐	**Yes**	☐	**No**	
	p. Dementia or degenerative neurologic disorders of viral or unknown etiology including, but not limited to Alzheimer's, Parkinsons, subacute sclerosing panencephalitis, progressive multifocal leukoencephalopathy, multiple sclerosis and ALS (Lou Gehrig's disease)	☐	**Yes**	☐	**No**	
	q. Meningitis or encephalitis	☐	**Yes**	☐	**No**	
	r. Autoimmune disorder (e.g., lupus, Crohn's disease and rheumatoid arthritis)	☐	**Yes**	☐	**No**	
	s. Creutzfeldt-Jakob disease (CJD or Bovine Spongiform Encephalopathy BSE) 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. Rabies	☐	**Yes**	☐	**No**	**If Yes,** how was it confirmed?
	x. An animal bite or scratch in the past 6 months (e.g., bat, skunk, dog, or other animal)	☐	**Yes**	☐	**No**	**If Yes,** what type of animal bit you?
	y. Were you treated for rabies?	☐	**Yes**	☐	**No**	**If Yes,** what type of treatment did you receive?
	z. Please provide additional information about any other health conditions or illnesses you have been treated for but that we did not ask about:					

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General Questions About Your Health

26	Have you been vaccinated or received an injection (needle) for any reason **in the last 8 weeks?**	☐ **Yes**	☐ **No**
26a.	**If Yes,** what was the vaccination or injection, and why did you get it?		

27	Tuberculosis (TB) **Have you ever:**		
	a. been tested for TB? **If yes** please describe below (section h)	☐ **Yes**	☐ **No**
	b. been diagnosed with TB?	☐ **Yes**	☐ **No**
	c. had a positive TB skin or blood 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. lived or worked in an area with a high incidence of TB?	☐ **Yes**	☐ **No**
	h. **If you answered "Yes:** to any question about TB or are unsure how to answer a question, please provide details:		

28	Have you ever had a psychiatric or emotional illness?	☐ **Yes**	☐ **No**
29	Have you ever seen a mental health professional, or are you currently seeing a mental health professional?	☐ **Yes**	☐ **No**
30	**In the past 5 years,** have you been prescribed antidepressants, anti-anxiety medications, pain medications, or other similar medications? **If you answered "Yes"** to Questions 28, 29, and/or 30, please provide details:	☐ **Yes**	☐ **No**

31	**Have you ever received any of the following?**					**If you answer "Yes",** to any of these questions below, please state when and in what country	
	a. Human derived growth hormone	☐	**Yes**	☐	**No**	**When:** (*yyyy-mm-dd)*	**Country:**
	b. An organ or tissue transplant (e.g., bone, cornea, skin, kidney, liver, lung)	☐	**Yes**	☐	**No**	**When:** *(yyyy-mm-dd)*	**Country:**
	c. A graft or transplant of dura mater (brain/spinal tissue)	☐	**Yes**	☐	**No**	**When:** *(yyyy-mm-dd)*	**Country:**
	d. Injected bovine insulin (since 1980)	☐	**Yes**	☐	**No**	**When:** *(yyyy-mm-dd)*	**Country:**

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General Questions About Your Health							
31 cont.	**Have you ever received any of the following?**					**If you answer "Yes",** to any of these questions below, please state when and in what country	
	e. A blood transfusion or other blood product(s) (e.g., platelets, fresh frozen plasma, fibrinogen, IVIg, etc.), or IV (intravenous) infusions	☐	**Yes**	☐	**No**	**When:** *(yyyy-mm-dd)*	**Country:**
		Why:					

For Females Only (Biological Sex at Birth): ☐ Not Applicable			
32	Have you ever had a pap test? (**If No,** proceed to question 33)	☐ **Yes**	☐ **No**
32a.	When was your last pap test? ____/____/____ *yyyy mm dd*		
32b.	Have you ever had an abnormal Pap test?	☐ **Yes**	☐ **No**
32c.	**If Yes,** please explain:		
33	Have you ever had a mammogram? (**If No,** proceed to question 34)	☐ **Yes**	☐ **No**
33a.	**If Yes,** when was your last mammogram? ____/____/____ *yyyy mm dd*		
33b.	Have you ever had an abnormal mammogram?	☐ **Yes**	☐ **No**
33c.	**If Yes,** please explain:		
34	Have you ever been pregnant? **(If No,** proceed to question 35)	☐ **Yes**	☐ **No**
34a.	**If Yes,** how many times? **Pregnancies** **Miscarriages** **Abortions**		
34b.	**If Yes**, were you ever diagnosed with gestational diabetes (became diabetic during pregnancy)?	☐ **Yes**	☐ **No**
34c.	**If Yes,** you had gestational diabetes, describe any treatment:		
34d.	Did you ever have high blood pressure during pregnancy?	☐ **Yes**	☐ **No**
34e.	**If Yes,** describe any treatment:		
35	Are you currently pregnant or trying to become pregnant?	☐ **Yes**	☐ **No**
36	Do you have any plans for future pregnancies?	☐ **Yes**	☐ **No**
36a.	**If yes**, you are planning future pregnancies**,** please provide details:		

For Office Use - Local Donor ID #:	For Office Use - CTR Donor #:

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

37 Have you ever had a rectal prostate exam? ☐ **Yes** ☐ **No**

37a. **If Yes,** when was your last rectal prostate exam? ____/____/____ *yyyy mm dd*

38 Have you ever had a prostate-specific antigen (PSA) blood test? ☐ **Yes** ☐ **No**

38a. **If Yes,** when was your last PSA blood test? ____/____/____ *yyyy mm dd*

39 Have you ever had an abnormal prostate exam or PSA result? ☐ **Yes** ☐ **No**

39a. **If Yes,** please explain:

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.

Questions about smoking tobacco:

40 Do you currently smoke tobacco? ☐ **Yes** ☐ **No**

40a. **If Yes,** how long have you smoked?

40b. **If Yes,** how much do you smoke?

40c. **If No,** did you smoke in the past? ☐ **Yes** ☐ **No**

40d. **If you smoked in the past,** how much did you smoke?

40e. **If you smoked in the past,** for how long did you smoke?

40f. **If you smoked in the past,** when did you quit smoking? ____/____/____ *yyyy mm dd*

Questions about alcohol use:

41 Do you currently drink alcohol? ☐ **Yes** ☐ **No**

41a. **If Yes,** how often?

41b. **If Yes** to 41, how many drinks are consumed?

41c. **If No,** did you drink alcohol in the past? ☐ **Yes** ☐ **No**

41d. **If you drank alcohol in the past,** how much did you drink?

41e. **If you drank alcohol in the past,** for how long did you drink?

41f. **If you drank alcohol in the past,** when did you stop drinking? ____/____/____ *yyyy mm dd*

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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.

Questions about cannabis use:

42	Do you currently use cannabis?	☐ **Yes**	☐ **No**
42a.	**If Yes,** what is your method of use (e.g., smoking, oral, sublingual, topical)?		
42b.	**If Yes,** how often?		
42c.	**If No,** did you use cannabis in the past?	☐ **Yes**	☐ **No**
42d.	**If you used cannabis in the past,** how much did you use?		
42e.	**If you used cannabis in the past,** for how long did you use?		
42f.	**If you used cannabis in the past,** when did you stop using? *yyyy / mm / dd*		
43	Have you ever used non-prescription street drugs? (e.g., heroin, cocaine, crack, LSD, crystal meth, bennies, uppers, downers, speed, ecstasy, or anabolic steroids)	☐ **Yes**	☐ **No**
43a.	**If Yes,** what drug(s) and for how long did you use it/them?		
44	**In the past 3 months,** have you used intranasal (snorted) drugs for non-medical use?	☐ **Yes**	☐ **No**
45	**In the past 3 months,** have you ever used a needle to inject drugs into your vein(s), into a muscle, or under your skin for non-medical use? (i.e., intravenously, intramuscularly)	☐ **Yes**	☐ **No**
46	**In the past 3 months,** have you had sex with a person who has used a needle to inject drugs into his/her/their vein(s), into a muscle, or under the skin, for non-medical use?	☐ **Yes**	☐ **No**
47	Do you currently use medications not prescribed to you or misuse prescription or over-the-counter medication?	☐ **Yes**	☐ **No**
47a.	**If Yes,** what drug(s) and for how long did you use it/them?		
48.	**In the past 3 months,** have you had a new sexual partner and have had anal sex in the past 3 months?	☐ **Yes**	☐ **No**
48a.	**In the past 3 months,** have you had more than one sexual partner and have had anal sex in the past 3 months?	☐ **Yes**	☐ **No**
49.	**In the past 3 months,** have you exchanged sex for money or drugs?	☐ **Yes**	☐ **No**
49a.	**In the past 3 months,** have you had sex with a person who has exchanged sex for money or drugs?	☐ **Yes**	☐ **No**
50	**In the past 3 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**
51	**In the past 3 months,** to the best of your knowledge, have you had sex with any person whose medical, sexual, or social history you do not know well enough to accurately answer Questions 46, 48, 48a, 49a,50?	☐ **Yes**	☐ **No**
52	**In the past 3 months,** have you been in a jail, prison, or youth correctional facility for more than 72 consecutive hours?	☐ **Yes**	☐ **No**
53	**In the past 3 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**

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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.

54 **In the past 3 months,** have you had close contact with a person (e.g., someone who lives in the same household and shares kitchen and bathroom facilities with you) who has clinically active (symptoms of) hepatitis B or hepatitis C, or yellow jaundice? ☐ **Yes** ☐ **No**

55 **In the past 3 months,** have you had a tattoo, tattoo touch-up, permanent makeup, microblading, body modification, acupuncture, or an ear, body, or face piercing? ☐ **Yes** ☐ **No**

55a. **If Yes,** name of establishment and its location, name of the procedure and indicate if the instruments and/or ink used were contaminated or shared, or if non-sterile instruments were used?

Establishment	**City**	**Procedure**	**Yes,** they may have been contaminated, shared, or non-sterile	**No,** they were not contaminated, shared, or non-sterile	**Not Sure**
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Questions About Your Travel History

56 Have you ever lived outside of Canada and the United States? ☐ **Yes** ☐ **No**

57 Have you ever travelled outside of Canada and the United States? ☐ **Yes** ☐ **No**

58 In the **past 6 months,** have you travelled within Canada and the United States? ☐ **Yes** ☐ **No**

59 **If you answered Yes to Questions 56, 57and 58** state where you lived or travelled and when you returned:

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Questions About Your Travel History						
60	**Have you ever been exposed to, diagnosed with, or suspected of having, any of the following travel-related diseases?**					**If you answer "Yes",** to any of these questions below or are unsure how to answer, please provide more details:
	a. West Nile Virus	☐	**Yes**	☐	**No**	
	b. Malaria (or taken anti-malarial medications)	☐	**Yes**	☐	**No**	
	c. Chagas disease	☐	**Yes**	☐	**No**	
	d. Babesiosis	☐	**Yes**	☐	**No**	
	e. Leishmaniasis	☐	**Yes**	☐	**No**	
	f. Ebola	☐	**Yes**	☐	**No**	
	g. Strongyloides	☐	**Yes**	☐	**No**	
	h. Dengue	☐	**Yes**	☐	**No**	
	i. Zika virus	☐	**Yes**	☐	**No**	
	j. Did you exhibit any flu-like symptoms within 2 weeks of leaving a Zika virus risk area?	☐	**Yes**	☐	**No**	
	k. Any other travel-related disease(s)?	☐	**Yes**	☐	**No**	

Questions About Your Family History			
61	Do you have any children?	☐ **Yes**	☐ **No**
61a.	**If Yes,** how many? Ages:		
61b.	Do any of them have any health concerns? (**If Yes,** please provide details below in question 63.)	☐ **Yes**	☐ **No**
62	Do you have any brothers and/or sisters?	☐ **Yes**	☐ **No**
62a.	**If Yes,** how many? Ages:		
62b.	Do any of them have any health concerns? (**If Yes,** please provide below)	☐ **Yes**	☐ **No**

63	**Has anyone in your family been diagnosed with, or been treated for, any of the following?**					**If you answer "Yes,"** to any of these questions below or are unsure how to answer, please provide more details:
	a. Heart disease	☐	**Yes**	☐	**No**	
	b. Diabetes	☐	**Yes**	☐	**No**	
	c. Stroke	☐	**Yes**	☐	**No**	
	d. Cancer	☐	**Yes**	☐	**No**	

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Questions About Your Family History						
63 cont.	e. Kidney disease	☐	**Yes**	☐	**No**	
	f. Kidney stones	☐	**Yes**	☐	**No**	
	g. Liver disease	☐	**Yes**	☐	**No**	
	h. Bleeding problems	☐	**Yes**	☐	**No**	
	i. Tuberculosis (TB)	☐	**Yes**	☐	**No**	
	j. Creutzfeldt-Jakob Disease (CJD) or any prion-related disease	☐	**Yes**	☐	**No**	
	k. Any other major disease(s)?	☐	**Yes**	☐	**No**	

This section is for site-specific questions and is not required for participation in KPD

	☐ **Yes**	☐ **No**
	☐ **Yes**	☐ **No**
	☐ **Yes**	☐ **No**
	☐ **Yes**	☐ **No**

Additional Questions

64 **Is there any reason why you think you should not be an organ donor?** ☐ **Yes** ☐ **No**

64a. **If Yes,** please explain:

65 Were there any questions on this form that you did not understand or were unsure how to answer? ☐ **Yes** ☐ **No**

65a. **If Yes,** which question(s)?

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

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All Donors

Potential donor: please sign this form here:

Print Name of Potential Donor	Signature of Potential Donor	Date *(yyyy/mm/dd)*

67 Was this Medical and Social History Questionnaire completed by a person other than the potential donor? ☐ **Yes** ☐ **No**

67a. I**f Yes,** why was it completed by another person?

67b. **If Yes,** person completing this form for the potential donor to sign 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 - Local Donor ID #:	For Office Use - CTR Donor #:

For Office Use Only:
Comments/Follow-up:

Questionnaire reviewed and or interview conducted by *(print full name)*:_____

Signature:_____

Date *(yyyy/mm/dd):* _____

The Ottawa Hospital | L'Hôpital d'Ottawa

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,
i. 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

The Ottawa Hospital

- ❑ Civic
- ❑ General
- ❑ Riverside
- ❑ HI
- ❑ TRC
- ❑ TOHCC

health rec. no.

last name

first name

health insurance no. d.o.b. sex

REQUEST/CONSENT FOR RELEASE/DISCLOSURE OF PATIENT HEALTH INFORMATION

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)
X	X	X
Name of witness	Signature	Date (yyyy/mm/dd)
X	X	X

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:

KIDNEY DONOR EVALUATION CHECKLIST (PHASE 1)		
STEP	**INSTRUCTIONS**	**COMPLETE**
STEP 1: 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. • Please ensure **both** consents are signed and the dates indicated, are the same for yourself and your witness. • 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: 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. • Your Family Doctor needs to fax us back the completed form to 613-738-8403 (The fax number is also on the form). • 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: 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). • You may complete these tests at any lab that is convenient: Lifelabs, Dynacare, BioTest, or an Ottawa Hospital lab (Civic, Riverside, or General). • 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: Complete self-guided education session PowerPoint.	• Once Step 1 has been completed the Donor Clerk will email you a self-guided education PowerPoint and Review Form to be completed. **** This can be completed <u>before</u> completing your laboratory tests (Step 3) if you like.***	☐
STEP 5: 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 completed your education session.	☐