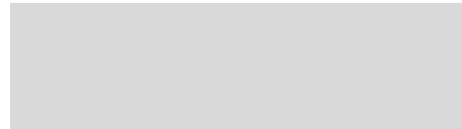


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Dear Potential Donor:

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:

--

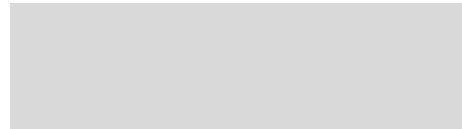
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**IF COMPLETING MANUALLY: COMPLETE IN INK (blue or black) - Do not use pencil. Answer all questions.**

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?)  Yes  No  
(If No, proceed to question 2)

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)) \_\_\_\_\_

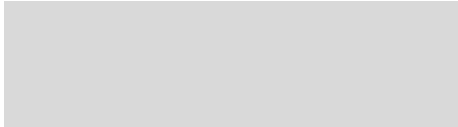
Website (which one?) \_\_\_\_\_

Other (please explain)



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**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**

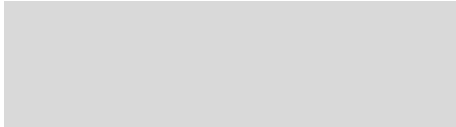
18 Have you ever been admitted to a hospital?  **Yes**  **No**

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

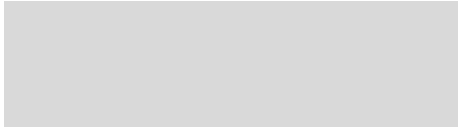
23 Have you ever had a reaction to anesthesia?  Yes  No

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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	b. Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	c. High blood pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	d. Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	e. Kidney stones	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	f. Kidney disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	g. Bladder or kidney infection	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	h. Thyroid disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	i. Bleeding problems, blood clots	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	j. Lung disease (e.g., asthma, sleep apnea, emphysema, chronic obstructive pulmonary disease [COPD])	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	k. Cancer (e.g., skin cancer, leukemia, lymphoma, or any other cancer)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	l. Stomach/bowel disorder (e.g., Crohn's disease, bloody stools, ulcerative colitis)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	m. Liver disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	n. Hepatitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

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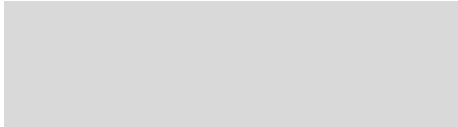


**General Questions About Your Health**

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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
q.	Meningitis or encephalitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
r.	Autoimmune disorder (e.g., lupus, Crohn's disease and rheumatoid arthritis)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
s.	Creutzfeldt-Jakob disease (CJD or Bovine Spongiform Encephalopathy BSE) or any prion-related disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
t.	Communicable disease(s) — viral, bacterial, or fungal (e.g., H1N1, swine flu, measles, cold sores)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
u.	Sexually transmitted infection(s) (e.g., syphilis, herpes, gonorrhea)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
v.	Any suspected or confirmed diagnosis of an emerging (developing) infectious disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
w.	Rabies	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, what type of animal bit you?
y.	Were you treated for rabies?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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:					

For Office Use - Local Donor ID #:

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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)				
	<b>Have you ever:</b>				
	a. been tested for TB? <b>If yes</b> please describe below (section h)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	b. been diagnosed with TB?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	c. had a positive TB skin or blood test?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	d. received treatment for TB?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	e. been vaccinated for TB?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	f. been exposed to someone with active TB?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	g. lived or worked in an area with a high incidence of TB?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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?  Yes  No

**If you answered "Yes"** to Questions 28, 29, and/or 30, please provide details:

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

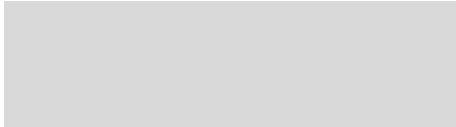






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**All Donors – Questions About Your Personal History**

*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
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Questions About Your Travel History**

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

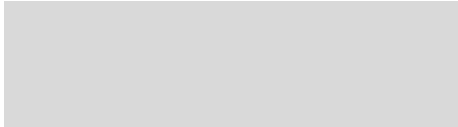
57 Have you ever travelled outside of Canada and the United States?  Yes  No

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, 57 and 58** state where you lived or travelled and when you returned:

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**Questions About Your Travel History**

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

**Questions About Your Family History**

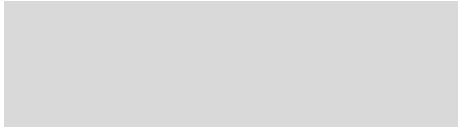
61	Do you have any children?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
61a.	<b>If Yes, how many?</b>	Ages:		
61b.	Do any of them have any health concerns? (If Yes, please provide details below in question 63.)	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
62	Do you have any brothers and/or sisters?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
62a.	<b>If Yes, how many?</b>	Ages:		
62b.	Do any of them have any health concerns? (If Yes, please provide below)	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

63	<b>Has anyone in your family been diagnosed with, or been treated for, any of the following?</b>				<b>If you answer "Yes," to any of these questions below or are unsure how to answer, please provide more details:</b>
----	--	--	--	--	---

a.	Heart disease	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
b.	Diabetes	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
c.	Stroke	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
d.	Cancer	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

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**Questions About Your Family History**

63 cont.	e. Kidney disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	f. Kidney stones	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	g. Liver disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	h. Bleeding problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	i. Tuberculosis (TB)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	j. Creutzfeldt-Jakob Disease (CJD) or any prion-related disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
	k. Any other major disease(s)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

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

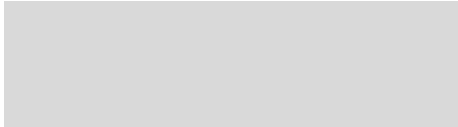
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Additional Questions**

64	<b>Is there any reason why you think you should not be an organ donor?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
64a.	<b>If Yes, please explain:</b>	
65	<b>Were there any questions on this form that you did not understand or were unsure how to answer?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
65a.	<b>If Yes, which question(s)?</b>	

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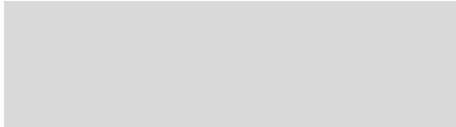
66 Add any additional information, questions, or comments you may have. If applicable, please indicate which question your comment refers to.

Large empty rectangular area for providing additional information, questions, or comments.

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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. **If 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)

\_\_\_\_\_

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**For Office Use Only:**  
Comments/Follow-up:

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

Signature: \_\_\_\_\_

Date (*yyyy/mm/dd*): \_\_\_\_\_

## 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

**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

Information pertaining to Living Kidney Donation

Other:

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.

<b>HEALTH RECORDS USE ONLY:</b> Date received:	TOTAL \$:	Received by:
--	-----------	--------------

KIDNEY DONOR EVALUATION CHECKLIST (PHASE 1)		
STEP	INSTRUCTIONS	COMPLETE
<p><b>STEP 1:</b> Send the donor program your Medical/Social/Travel (MST) questionnaire and signed consent forms</p>	<ul style="list-style-type: none"> <li>The MST questionnaire requires your <b>signature on page 4 as well as a witness</b> (the witness cannot be your intended recipient). Please ensure the date you write is the same date your witness writes.</li> <li>Please ensure <b>both</b> consents are signed and the dates indicated, are the same for yourself and your witness.</li> <li>The questionnaire and consents can be e-mailed to: (<a href="mailto:Livingkidneydonor@toh.ca">Livingkidneydonor@toh.ca</a>), faxed to: 613-738-8403 or mailed to: 1967 Riverside Dr. Box 643, Ottawa, ON, K1H 7W9.</li> </ul>	<input type="checkbox"/>
<p><b>STEP 2:</b> Make an appointment with your Family Doctor (if you have one)</p>	<ul style="list-style-type: none"> <li>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.</li> <li>Your Family Doctor needs to fax us back the completed form to 613-738-8403 (The fax number is also on the form).</li> <li>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.</li> </ul>	<input type="checkbox"/>
<p><b>STEP 3:</b> Complete laboratory tests</p>	<ul style="list-style-type: none"> <li>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).</li> <li>You may complete these tests at any lab that is convenient: Lifelabs, Dynacare, BioTest, or an Ottawa Hospital lab (Civic, Riverside, or General).</li> <li>You must be fasting for 12 hours. Do not eat or drink anything <b>except water</b> for 12 hours before you go to the lab.</li> </ul>	<input type="checkbox"/>
<p><b>STEP 4:</b> Complete self-guided education session PowerPoint.</p>	<ul style="list-style-type: none"> <li>Once Step 1 has been completed the Donor Clerk will email you a self-guided education PowerPoint and Review Form to be completed.</li> </ul> <p><b>* This can be completed <u>before</u> completing your laboratory tests (Step 3) if you like.</b></p>	<input type="checkbox"/>
<p><b>STEP 5:</b> Call/ e-mail the donor program</p>	<ul style="list-style-type: none"> <li>Call (613-738-8400 ext. 82719) or e-mail (<a href="mailto:Livingkidneydonor@toh.ca">Livingkidneydonor@toh.ca</a>) 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.</li> </ul>	<input type="checkbox"/>