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Santé et Services sociaux Québec

DT9474

User's first and last name

Date of birth (yyyy/mm/dd) | Age | Sex ☐ M ☐ F

Address (number, street)

City | Postal code

Health Insurance Number | Record number

LIVING KIDNEY DONOR SCREENING QUESTIONNAIRE

Unique Donor Number (UDN)	

Name of Establishment

- ☐ CHUM – Centre hospitalier de l'Université de Montréal
- ☐ CHU de Québec – UL – Pavillon L'Hôtel-Dieu de Québec
- ☐ CIUSSS de l'Estrie – CHUS – Hôpital Fleurimont
- ☐ CIUSSS de l'Est-de-l'Île-de-Montréal – Hôpital Maisonneuve-Rosemont
- ☐ CUSM – Site Glen

Date of the first contact (phone call or meeting) with the potential donor (year, month, day): _____

Information about the potential donor

Last name	First name	Gender ☐ M ☐ F
Health Insurance Number (HIN)		Expiry date (year, month)
Date of birth (year, month, day)	Place of residence (province/country)	
Citizenship	Ethnic origin	Marital status
Occupation/work		Number of children and their respective ages
Area code Home phone number	Area code Work phone number	Area code Cellular phone number
Email address		Mailing address
Father's last and first name		Mother's last and first name
Family doctor's last and first name		Doctor's address
Area code Phone number:	Area code Fax number:	Date of last visit (year, month, day)
Reason for visit		

Have you ever been evaluated for organ or tissue donation?

☐ No ☐ Yes Specify:

User's first and last name	Record number

Information about the recipient	
Recipient's last name and first name (if known)	What is your relationship to the intended recipient (if known)?
Section reserved for the establishment	
Record number	Blood type (A, B, AB, or O)
Nephrology centre that referred the recipient to the transplant centre	Recipient's status ☐ Not evaluated ☐ Predialysis ☐ Under evaluation ☐ Hemodialysis ☐ Temporary withdrawal ☐ Peritoneal dialysis ☐ Approved ☐ Information not available
	Dialysis start date (if dialyzed): (Year, Month, Day)

Questions about the proposed donation

How did you learn about the Living Kidney Donor Program?

- ☐ From the recipient
- ☐ From a doctor. Specify: _____
- ☐ During a patient information session. Specify: _____
- ☐ Through the media (e.g., newspaper). Specify: _____
- ☐ A website. Specify: _____
- ☐ Other. Specify: _____

Why do you wish to donate a kidney?

User's first and last name	Record number

Potential donor's lifestyle

Do you or have you ever smoked? ☐ No, never ☐ Yes, currently ☐ Yes, I used to

If so, since when or for how long? _____

☐ Regular cigarettes ☐ E-cigarettes How many cigarettes per day? _____

Do you drink alcohol? ☐ No, never ☐ Yes, currently ☐ Yes, I used to

If so, since when or for how long? _____ How many drinks per week? _____

Do you use cannabis? ☐ No, never ☐ Yes, currently ☐ Yes, I used to

If so, since when or for how long? _____ For how long? _____

Do you use illegal drugs? ☐ No, never ☐ Yes, currently ☐ Yes, I used to

If so, which ones? _____ For how long? _____

Have you ever been treated for drug or alcohol dependence?

☐ No ☐ Yes

Do you currently take medication on a regular basis (prescribed or over-the-counter) or natural products ?

☐ No ☐ Yes If so, specify: _____

Name of drug	Reason	Dose	Frequency

Potential donor's medical information and medical and surgical history

Enter the following, if known your :

Weight: Height: Blood type (A, B, AB, or O):

Reserved for the institution	Body Mass Index (BMI)	Blood type (A, B, AB, or O)

Section reserved for female donors only

Number of pregnancies	Number of abortions or miscarriages	Number of births

During your pregnancies, were you diagnosed with?

☐ High blood pressure ☐ Pre-eclampsia

☐ Diabetes ☐ Other. Specify: _____

Have you ever had a Pap test or a gynecological exam?

☐ No

☐ Yes Date of last test: _____

Have you ever had a mammogram?

☐ No

☐ Yes Date of last test: _____

User's first and last name	Record number

Have you ever been diagnosed or been treated for any of the following health problems?

Allergies
☐ No
☐ Yes Specify: _____

Diabetes
☐ No
☐ Yes Since when? _____
Treatment: ☐ Diet ☐ Pills ☐ Insulin

Urinary tract infection
☐ No
☐ Yes Treatment: ☐ Oral ☐ Intravenous

Kidney disease
☐ No
☐ Yes Specify: _____

Kidney stones
☐ No
☐ Yes Number of episodes: _____
Last episode: _____

High blood pressure
☐ No
☐ Yes Since when? _____
Treated since when? _____

Heart disease
☐ No
☐ Yes Specify: _____
Since when? _____
Treated since when? _____

Cancer
☐ No
☐ Yes Which type? _____
In what year? _____

Liver disease
☐ No
☐ Yes Specify: _____

Thyroid disease
☐ No
☐ Yes Specify: _____

Disease of the nervous system
☐ No
☐ Yes Specify: _____

Respiratory disease
☐ No
☐ Yes Specify: _____

Tuberculosis
☐ No
☐ Yes When? _____

Psychiatric illness/ psychological disorder
☐ No
☐ Yes Specify: _____

Thrombophlebitis
☐ No
☐ Yes When? _____

Bleeding or coagulation disorder
☐ No
☐ Yes Specify: _____
Hemophilia ☐ No ☐ Yes

Have you ever had a blood transfusion?
☐ No
☐ Yes When? _____

Have you ever had a colonoscopy?
☐ No
☐ Yes When? _____

Autoimmune disease
☐ No
☐ Yes Specify: _____
Lupus ☐ No ☐ Yes

Other health problem
☐ No
☐ Yes Specify: _____

Hospitalizations and surgeries
☐ No
☐ Yes Specify:

User's first and last name	Record number

Potential donor's family history

Has a member of your immediate family (father, mother, brother, or sister) ever had one or more of the following

	No	Yes	Father	Mother	Brother(s)	Sister(s)	Comments
Heart disease	☐	☐					
Bleeding problems	☐	☐					
Cancer	☐	☐					
High blood pressure	☐	☐					
Kidney disease	☐	☐					
Kidney stones	☐	☐					
Diabetes	☐	☐					
Mental health problem	☐	☐					
Other hereditary family disease	☐	☐					

If so, specify: _____

Important information to be provided to the potential donor

In Canada, no valuable incentives, goods, or services may be offered to a living donor or third party in exchange for organs. Donations are made on a voluntarily basis.

A medical and psychological evaluation is required to establish your eligibility for donation. The length of this evaluation may vary depending on your case.

You will have to travel to the institution for your medical evaluation. A recovery period of a few weeks is required after donation.

There is a reimbursement program for living donors' expenses. Details of this program will be provided during your meeting with the living donor nurse.

I understand the importance of the accuracy of the information provided on this form in assessing my eligibility for donation and certify that I have answered the above questions truthfully and to the best of my knowledge.

Form completed by the ☐ Nurse during a phone call with the potential donor
☐ Potential donor

Signature of potential donor		Date (year, month, day)
Signature of nurse	**Licence no.:**	**Date (year, month, day)**

Does the questionnaire need to be reviewed by a nephrologist? ☐ No ☐ Yes

Physician's signature

Name (printed)	Licence no.	Signature	Date (year, month, day)