



DT9453

LIVING DONOR PHYSICAL EXAM FORM

Living Donor Identification Number – Kidney Paired Donation Program	
Unique Donor Number (UDN)	

User's first and last name		
Date of birth (yyyy/mm/dd)	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (number, street)		
City	Postal code	
Health Insurance Number	Record number	

Name of Establishment		
<input type="checkbox"/> CHUM – Centre hospitalier de l'Université de Montréal	<input type="checkbox"/> CIUSSS de l'Estrie – CHUS -- Hôpital Fleurimont	<input type="checkbox"/> CUSM – Site Glen
<input type="checkbox"/> CHU de Québec – UL – Pavillon L'Hôtel-Dieu de Québec	<input type="checkbox"/> CIUSSS de l'Est-de-l'Île-de-Montréal – Hôpital Maisonneuve-Rosemont	

The living donor physical examination includes assessment for evidence that may indicate high-risk behaviour potentially associated with risk of transmissible disease, bacterial or viral infection, malignancy and trauma.

Assess for the following physical signs as potential evidence of transmissible disease		
Evaluation Abbreviation: E. D. = Exceptional distribution	Abbreviations: V/I = Verification Impossible, N/A = Not Applicable	Explanations/comments If "Yes" or "V/I"
Signs of sexually transmitted diseases (STD) e.g., genital ulcers, herpes simplex, syphilis, chancroid [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Male donor: evidence of anal intercourse including perianal condyloma [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Evidence of nonmedical percutaneous drug use such as needle tracks (examine tattoos where applicable, as they may cover needle tracks) [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Evidence of recent tattooing, ear or body piercing dating back less than 1 year	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Unexplained lymphadenopathy (swollen lymph node) [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Oral thrush	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Blue or purple spots on skin or mucous membranes consistent with Kaposi's sarcoma [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Unexplained jaundice or hepatomegaly or icterus [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Evidence of sepsis, such as unexplained generalized rash [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Large scab consistent with recent smallpox immunization [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Eczema vaccinatum [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Generalized vesicular rash (generalized vaccinia) [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Severely necrotic lesion consistent with vaccinia necrosum [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Corneal scarring consistent with vaccinal keratitis [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Unexplained lesions or infections of the skin or mucous membranes [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	
Palpable mass in abdomen, soft tissue, breasts, or other areas, suspicious of neoplasm [E. D.]	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A	

User's first and last name	Record number
----------------------------	---------------

Assess for the following physical signs as potential evidence of transmissible disease (continued)																		
Evaluation Abbreviation: E. D. = Exceptional distribution	Abbreviations: V/I = Verification Impossible, N/A = Not Applicable	Explanations/comments If "Yes" or "V/I"																
Evidence of an active infection or malignancy of clinical significance (e.g., by inspection and palpation) E. D.	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A																	
Evidence of alteration in mental or neurological status E. D.	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A																	
<p>Legend Mark corresponding letter on diagram.</p> <table border="0"> <tr> <td>A Abrasion(s)</td> <td>R Rash or skin lesions</td> </tr> <tr> <td>B Bruise(s)</td> <td>S Scar(s)</td> </tr> <tr> <td>C Contusion(s)</td> <td>T Tattoo(s)</td> </tr> <tr> <td>D Dressing(s)</td> <td>Q Lesion(s) or wound(s)</td> </tr> <tr> <td>H Hematoma(s)</td> <td>U Mass(es)</td> </tr> <tr> <td>L Laceration(s)</td> <td>V Nothing to indicate</td> </tr> <tr> <td>N Needle tracks (non-medical)</td> <td>W Other</td> </tr> <tr> <td>P Piercing(s)</td> <td></td> </tr> </table> <p>Comments:</p> <hr/> <hr/> <hr/> <hr/>			A Abrasion(s)	R Rash or skin lesions	B Bruise(s)	S Scar(s)	C Contusion(s)	T Tattoo(s)	D Dressing(s)	Q Lesion(s) or wound(s)	H Hematoma(s)	U Mass(es)	L Laceration(s)	V Nothing to indicate	N Needle tracks (non-medical)	W Other	P Piercing(s)	
A Abrasion(s)	R Rash or skin lesions																	
B Bruise(s)	S Scar(s)																	
C Contusion(s)	T Tattoo(s)																	
D Dressing(s)	Q Lesion(s) or wound(s)																	
H Hematoma(s)	U Mass(es)																	
L Laceration(s)	V Nothing to indicate																	
N Needle tracks (non-medical)	W Other																	
P Piercing(s)																		

Physical Exam – continued						
Height	Weight		Body Mass Index (BMI)	Abdominal circumference	Pulse (BPM)	
cm	kg			cm	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular	
Blood pressure	Right arm	Left arm	BP Tru	Name	Signature	
Normal exam	Abbreviations: V/I = Verification Impossible, N/A = Not Applicable			Explanations/comments If "No" or "V/I"		
General appearance	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Head and neck	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Cardiovascular system	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Respiratory system	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Genitourinary	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Digital rectal exam (DRE)*	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Testicular exam	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Extremities	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					
Other	<input type="checkbox"/> Yes <input type="checkbox"/> V/I <input type="checkbox"/> No <input type="checkbox"/> N/A					

* Digital rectal exam (to be done for men age 50 or older, or 45 or older if user is black or has a first-degree family history of prostate neoplasm)

