Santé et Services sociaux Québec

DT9474

# LIVING KIDNEY DONOR SCREENING QUESTIONNAIRE

| | | |
|---|---|---|
| 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 | |

| | |
|---|---|
| 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<br>☐ Not evaluated ☐ Predialysis<br>☐ Under evaluation ☐ Hemodialysis<br>☐ Temporary withdrawal ☐ Peritoneal dialysis<br>☐ 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 |
|---|---|---|---|
| | | | |
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## 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) |
|---|---|---|---|
| | | | |