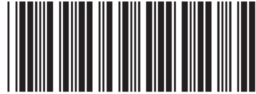
Santé
et Services sociaux
Québec



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 ☐ M ☐ F
Address (number, street)		
City		Postal code
Health Insurance Number		Record number

Name of Establishment

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

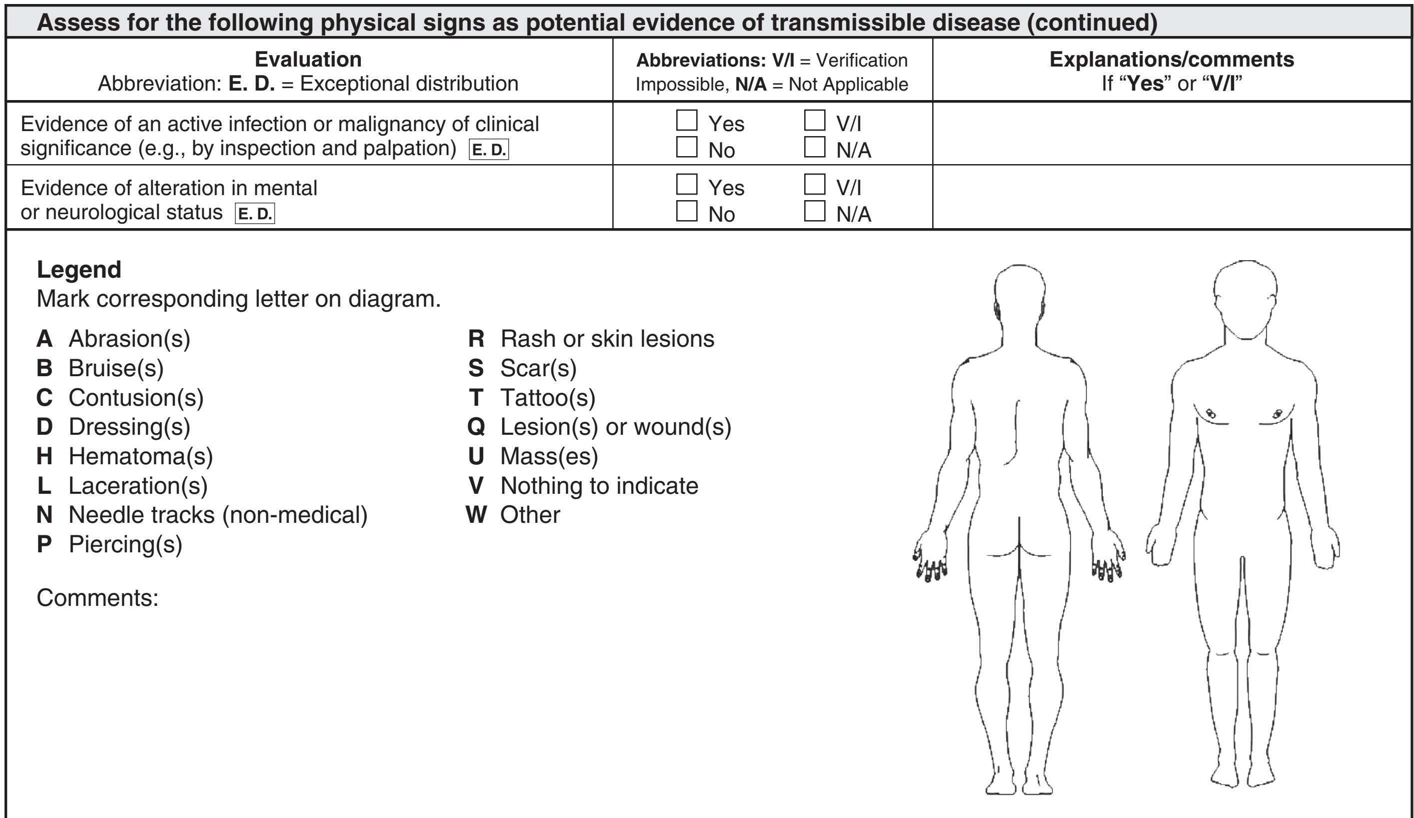
The living donor physical examination includes assessment for evidence that may indicate high-risk behaviour potentially associated with risk of transmissible disease, bacterial or viral infection, malignancy and trauma.

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.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Male donor: evidence of anal intercourse including perianal condyloma E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Evidence of nonmedical percutaneous drug use such as needle tracks (examine tattoos where applicable, as they may cover needle tracks) E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Evidence of recent tattooing, ear or body piercing dating back less than 1 year	☐ Yes ☐ V/I ☐ No ☐ N/A	
Unexplained lymphadenopathy (swollen lymph node) E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Oral thrush	☐ Yes ☐ V/I ☐ No ☐ N/A	
Blue or purple spots on skin or mucous membranes consistent with Kaposi's sarcoma E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Unexplained jaundice or hepatomegaly or icterus E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Evidence of sepsis, such as unexplained generalized rash E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Large scab consistent with recent smallpox immunization E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Eczema vaccinatum E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Generalized vesicular rash (generalized vaccinia) E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Severely necrotic lesion consistent with vaccinia necrosum E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Corneal scarring consistent with vaccinial keratitis E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Unexplained lesions or infections of the skin or mucous membranes E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Palpable mass in abdomen, soft tissue, breasts, or other areas, suspicious of neoplasm E. D.	☐ Yes ☐ V/I ☐ No ☐ 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.	☐ Yes ☐ V/I ☐ No ☐ N/A	
Evidence of alteration in mental or neurological status E. D.	☐ Yes ☐ V/I ☐ No ☐ N/A	



Physical Exam – continued				
Height cm	Weight kg	Body Mass Index (BMI)	Abdominal circumference cm	Pulse (BPM) ☐ Regular ☐ 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	☐ Yes ☐ V/I ☐ No ☐ N/A	
Head and neck	☐ Yes ☐ V/I ☐ No ☐ N/A	
Cardiovascular system	☐ Yes ☐ V/I ☐ No ☐ N/A	
Respiratory system	☐ Yes ☐ V/I ☐ No ☐ N/A	
Abdomen	☐ Yes ☐ V/I ☐ No ☐ N/A	
Genitourinary	☐ Yes ☐ V/I ☐ No ☐ N/A	
Digital rectal exam (DRE)*	☐ Yes ☐ V/I ☐ No ☐ N/A	
Testicular exam	☐ Yes ☐ V/I ☐ No ☐ N/A	
Extremities	☐ Yes ☐ V/I ☐ No ☐ N/A	
Lymph nodes	☐ Yes ☐ V/I ☐ No ☐ N/A	
Other	☐ Yes ☐ V/I ☐ No ☐ 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)

User's first and last name	Record number

Comments

Physican signature			Date		
Name (printed)	License No.	Signature	Year	Month	Day