Healthcheck Questionnaire

LIVING KIDNEY DONATION — The Exceptional Gift

Your details (potential donor)	
Name	
Date of Birth	
Address	
Contact Numbers Mobile Home	
E-mail address	
Ethnicity	
GP – Name, address and telephone number	

Intended recipient	
Altruistic donation (to a stranger)?	Yes ☐ No ☐
If no, name and date of birth of intended recipient	
Hospital they attend for renal care / dialysis	
Your relationship to the recipient	
Have you discussed the possibility of living donation with the recipient?	Yes ☐ No ☐

Where did you hear about living kidney donation?			
Renal Unit	Yes ☐ No ☐	Potential Recipient	Yes ☐ No ☐
Renal/Low clearance clinic	Yes ☐ No ☐	Media/TV/Internet/ Radio	Yes ☐ No ☐
Home Education Nurse	Yes ☐ No ☐	GP	Yes ☐ No ☐
Family/Friends	Yes ☐ No ☐	Other	Yes ☐ No ☐
Have you discussed the possibility of living donation with your family?		Yes ☐ No ☐	

Health Questionnaire (1)

Name		Date of Birth	

Current Medication - Both prescribed and over the counter eg paracetamol			
Drug Name	Dose	Frequency	Reason if known
Please list any known allergies:			

Height:		Weight:	
Smoking – Are you a current smoker?		Yes ☐ No ☐	
Cigarettes	Yes ☐ No ☐	E-Cigarette	Yes ☐ No ☐
Ex-smoker	Yes ☐ No ☐	Date stopped	
Alcohol – Do you drink alcohol?		Yes ☐ No ☐	Number of units per week?
Recreational Drugs – Do you currently use recreational drugs?	Yes ☐ No ☐	Have you used recreational drugs in the past?	Yes ☐ No ☐
Details:			
Have you had any tattoos or piercings in the last 6 months?		Yes ☐ No ☐	
Bowel Screening (over 50's only)	Date		Normal ☐ Abnormal ☐
Have you ever been a blood donor?		Yes ☐ No ☐	

Women only

Screening	**Date**	**Result**	**Follow up**
Smear (women age 25-64)		Normal ☐ Abnormal ☐	Yes ☐ No ☐
Mammogram (women over 50)		Normal ☐ Abnormal ☐	Yes ☐ No ☐
Do you take the contraceptive pill?		Yes ☐ No ☐	
Hormone Replacement Therapy (HRT)		Yes ☐ No ☐	
How many pregnancies have you had?		Number: ☐	

During your pregnancies did you suffer from any of the following:

High blood pressure	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Protein in your urine	Yes ☐ No ☐

Men only

Have you had any problems with your prostate?	Yes ☐ No ☐

Health Questionnaire (2)

Name		Date of Birth	

Do you have or have you ever experienced...			
High blood pressure	Yes ☐ No ☐	Palpitations	Yes ☐ No ☐
Chest pain/angina	Yes ☐ No ☐	Heart murmur	Yes ☐ No ☐
Heart attack (M.I)	Yes ☐ No ☐	Lung disease e.g. asthma/ COPD etc	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Kidney stones	Yes ☐ No ☐
Urine Infections	Yes ☐ No ☐	Protein or blood in your urine	Yes ☐ No ☐
Have you ever been seen by an Urologist?	Yes ☐ No ☐	Have you ever had problems passing urine?	Yes ☐ No ☐
Clotting/bleeding problems (inc. deep venous thrombosis)	Yes ☐ No ☐	Crohn's Disease / Ulcerative Colitis	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Chronic Pain	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Depression/Anxiety	Yes ☐ No ☐	Have you required input from mental health services?	Yes ☐ No ☐
Have you had an operation / general anaesthetic in the past	Yes ☐ No ☐	Have you ever attended clinics or been admitted to hospital?	Yes ☐ No ☐
Have you travelled outside Europe/North America in last 12 months?	Yes ☐ No ☐	Have you ever been refused as a blood donor?	Yes ☐ No ☐
If yes to any of the above please give details:			

I have completed this questionnaire to the best of my knowledge			
Signature		Date	

Please also complete the GP contact form below and send both forms together.

Permission to contact General Practitioner and access medical records

It is necessary that we review your medical records and contact your General Practitioner (GP) for any relevant information that may be important to our assessment of you as a potential living kidney donor.

We would therefore request your written permission to contact your GP requesting your medical history to be forwarded to us and review your hospital records. Any information received will be dealt with confidentially.

I give permission for the living donor assessment team to contact my GP and review my medical records for the purposes of living kidney donor assessment.

Your name (print)	
Signature	
Date	

Thank you for volunteering to be considered as a potential living kidney donor. You can print and send by post, or email your saved version of this form to your local living donor transplant team (please contact your local unit).

Alternatively, send this form to your closest transplant centre. Your details will then be forwarded to your local unit.

Thanks!

Edinburgh
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