

Healthcheck Questionnaire

LIVING
KIDNEY
DONATION

The
Exceptional
Gift

Your details (potential donor)

Name	
Date of Birth	
Address	
Contact Numbers Mobile Home	
E-mail address	
Ethnic background	
GP - Name, address and telephone number	

Intended recipient

Non Directed Altruistic Donation (to someone you don't know)	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>

Where did you hear about living kidney donation?

Potential Recipient	Yes <input type="checkbox"/> No <input type="checkbox"/>
Social media/TV/Radio/Newspaper	Yes <input type="checkbox"/> No <input type="checkbox"/>
REACH Transplant (home education)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Family/Friends	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>

Health Questionnaire (1)

Name		Date of Birth	
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Current Medication - Both prescribed and over the counter eg paracetamol

Drug Name	Dose	Frequency	Reason if known

Please list any known allergies:

Height:		Weight:	
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Smoking - Are you a current smoker? Yes No

Cigarettes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vaping	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ex-smoker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date stopped	
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Alcohol - Do you drink alcohol? Yes No Number of units per week?

Recreational Drugs - Do you currently use recreational drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you used recreational/IV drugs in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Details:	
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Have you had any tattoos, cosmetic tattoos or piercings in the last 6 months? Yes No

Bowel Screening (over 50's only)	Date	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
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Women only

Screening	Date	Result	Follow up
Smear (women age 25-64)		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mammogram (women over 50)		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Men only

Have you had regular screening or had any problem with your prostate?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Health Questionnaire (2)

Name		Date of Birth	
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Do you have or have you ever experienced...

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

I have completed this questionnaire to the best of my knowledge

Signature		Date	
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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

Living Donor Transplant
Co-ordinators
Edinburgh Transplant Centre
Royal Infirmary of Edinburgh
Little France Crescent
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Email

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Glasgow

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