AlfredHealth

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☐ Alfred ☐ Sandringham ☐ Caulfield

KIDNEY DONOR HEALTH SCREENING QUESTIONNAIRE

Family Name*		Given Name*	
Date of Birth*		Sex ☐ Female ☐ Male	

*mandatory fields

This questionnaire will help reconcile your health background, to begin your assessment towards organ donation. It is really important all your past and present health issues are considered. Take the time to answer the questions to the best of your ability. Contact your GP or other doctors if required, to provide correct information.

Steps to completing this questionnaire:

1. Save questionnaire to your computer
2. Complete questionnaire & email to renaltransplant@alfred.org.au
3. or post to: Renal Transplant Coordinators-Renal Department, Alfred Health, PO Box 315, PRAHRAN VIC 3181

• A referral from your GP is also required, to be emailed or posted with this questionnaire
• If you wish to withdraw from this process at any time, notify the transplant coordinators

Renal Transplant Unit T 03 9076 6530 F 03 9076 3494

Patient Details					
Address					
Email		Telephone			
Interpreter ☐ Yes ☐ No	Language				
Aboriginal or Torres Strait Islander	☐ Yes, list		☐ No ☐ Not specified		
☐ Bulk Bill ☐ Private ☐ Pensioner ☐ DVA ☐ Other					
Medicare Number		Reference		Exp	
Alternative Contact	Name				
	Relationship				
	Phone				
General Practitioner	Name				
	Address				
Person you intend donating kidney to	Name				
	Relationship				

Medical History	*Attach a list if below space is too small*
Do you have any health problems	☐ Yes, list ☐ No
Have you been in hospital for health problems or surgeries	☐ Yes, list ☐ No
Have you seen any specialist doctors in the last five years	☐ Yes, list ☐ No
Have you had any recent anaesthetics	☐ Yes, list and dates ☐ No
Have you had any complications to an anaesthetic	☐ Yes, describe ☐ No

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Family Name*		Given Name*	

Current Health					
Allergies	☐ Yes, *list* ☐ No				
What is your height		What is your weight		BMI, *if known*	

Medication	*Attach a list if below space is too small*
Do you use any medications regularly? Prescription tablets, puffers, herbal, non prescribed tablets	☐ Yes ☐ No

Medication name	**How much** *(dose)*	**How often each day** *(frequency)*

Do you have, or have you ever had			
High blood pressure	☐ No	☐ Yes, when	
Chest pain or “angina”	☐ No	☐ Yes, how often	
Heart attack	☐ No	☐ Yes, when	
Other heart condition (eg, pacemaker)	☐ No	☐ Yes, what type	
Lung Problems needing hospitalisation	☐ No	☐ Yes, what type	
Shortness of breath	☐ No	☐ Yes, when	
Chronic Bronchitis	☐ No	☐ Yes, when	
Asthma	☐ No	☐ Yes, how often	
Sleep Apnoea	☐ No	☐ Yes, on CPAP	
Reflux of acid/food (eg heart burn, hiatus hernia)	☐ No	☐ Yes, how often	
Diabetes	☐ No	☐ Yes	☐ Yes I use insulin or take a diabetic tablet
Epilepsy or fits	☐ No	☐ Yes, how often	
Stroke	☐ No	☐ Yes, when	
Blackouts or fainting	☐ No	☐ Yes, when	

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Do you have, or have you ever had *cont*			
Blood clots or a bleeding disorder	☐ No	☐ Yes, what type	
Anaemia	☐ No	☐ Yes, when	
Previous Blood transfusion	☐ No	☐ Yes, when	
Kidney condition	☐ No	☐ Yes, what type	
Hepatitis or liver condition	☐ No	☐ Yes, what type	
Your doctor prescribed you steroids (eg Cortisone or prednisolone)	☐ No	☐ Yes, when	
Any conditions that run in the family (eg Thalassemia, muscular dystrophy)	☐ No	☐ Yes, what	
Any other health issues not already noted (eg hormone therapy, poor teeth, Rheumatoid arthritis)	☐ No	☐ Yes, what	
Any infectious diseases (golden staph, HIV, TB)	☐ No	☐ Yes, what	

Are you pregnant?	☐ No	☐ Yes ☐ Maybe	
Do you smoke?	☐ No	☐ Yes, how much	
Do you drink alcohol?	☐ No	☐ Yes, how much per week	
Do you take illicit drugs?	☐ No	☐ Yes, what	
Have you had Skin Cancer?	☐ No	☐ Yes, add details below	
Have you had any other form of cancer	☐ No	☐ Yes, add details below	
Additional information you wish to provide			

Completion			
Name of person completing this Questionnaire			
Relationship, *if not the patient*		Date	

Information provided with this questionnaire:
Kidney Donation by Live Donors booklet *and* Living Kidney Donation Fact Sheet, from Kidney Health Australia

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