The Leeds Teaching Hospitals NHS
NHS Trust

Living Donor Liver Transplant Program
Donor Health Questionnaire

To help us assess if you would be suitable to be a living donor, please complete this health questionnaire, and send it along with a copy of your blood group (if known)

ONLY COMPLETE THIS FORM WHEN THE RECIPIENT IS ON THE LIVER TRANSPLANT LIST

This form can be submitted electronically to leedsth-tr.livedonor@nhs.net or by post to: *Live Liver Donor Co-ordinators, Level 6, Bexley Wing, St James's University Hospital, Beckett Street, Leeds LS9 7TFS9 7* TF.

For help and advice call 0113 2066913

Before Completing this form, please read the information on live liver donation on our website, including the leaflet "Information for potential living liver donors: www.leedsth.nhs.uk/a-z of services/leeds-liver-unit/liver-transplant-program/live-donor-liver-transplant-program/

Please tick the box to confirm you have read and understood this information ☐

Version 3: January 25

DONOR DETAILS

Please enter your personal details below (Required field)

Full Name			
Date of birth		Age	
Gender			
NHS number (if known)			
Marital Status			
Country of birth			
Citizenship			
Race/Ethnicity			
Address			
Postcode			
Home telephone			
Mobile telephone			
Email address			
GP name			
GP address			
GP telephone			
Blood Group (if known)		Do you have a copy?	

Leeds Liver Unit

NHS
The Leeds Teaching Hospitals
NHS Trust

DONOR DETAILS (cont d)

Height (in metres)	
Weight (in kilograms)	
(Office use only) BMI	
Waist circumference (in cms)	
Hip circumference (in cms)	
(Office use only) Waist/Hip ratio	
Occupation	
Do you have any dependents?	

RECIPIENT DETAILS

If you are directing your donation to a specific recipient, please enter their details below. **If you wish to be an altruistic donor please tick the first box and leave the rest blank.** ONLY COMPLETE THIS FORM WHEN THE RECIPIENT IS ON THE LIVER TRANSPLANT LIST

I wish to be an altruistic donor ☐

Recipient full name	
Date of birth	
Relationship to recipient	
(Office use only) Recipient blood group	
Have you discussed your wish to donate with the intended recipient?	
Have you discussed your wish to donate with your family/friends?	

Why do you wish to donate?	

These questions are used to gather important information about your health and lifestyle that might impact on your potential to become a living donor. This information will be used by the health care professionals on our team to determine your overall well-being.

GENERAL HEALTH

Have you had any abdominal surgery?	
If YES, please give details	
Have you had any other type of surgery?	
If YES, please give details	
Did you have any problems after surgery/ anaesthetic?	
If YES, please give details	
Have you had any hospitalisation for other reasons?	
If YES, please give details, including which hospital	
Do you routinely take any medications?(Including over the counter and herbal medications)	
If YES, please give details	
Please tell us about any allergies	

Do you smoke or vape?	
It YES, please give details, including what, how many and for how long	
If you have stopped smoking or vaping when did you stop?	
Do you drink alcohol?	
It YES, how many drinks per week? 1 drink=1 bottle of beer, 1 glass of wine or 1 measure of spirit	
In the last 6 months have you injected or been injected with non-prescription drugs including performance enhancing drugs or injectable tanning agents (eg. Melotan, Mitogive, Oxandrolone, Stanozolol or Nandrolene)	
If YES, please give details, including dates.	
Have you had any unexplained weight loss?	
If YES, please give details	

LIVER HEALTH

Have you ever had jaundice (yellow skin)?	
If YES, please give details	
Have you ever had a liver problem?	
If YES, please give details	

Have you ever had an inflamed liver?	
If YES, please give details	
Is there a family history of liver problems?	
If YES, please give details	

CANCER HISTORY

Have you ever had cancer?	
If YES, please give details (including type of cancer, date of diagnosis and treatment)	
Is there a family history of cancer?	
If YES, please give details Including relation, and type of cancer	

INFECTION RISKS

Have you ever received any blood/blood products?	
If YES, please give details	
Have you ever been told you cannot donate blood?	
If YES, please give details	

In the last 6 months, have you had ANY cosmetic tattoos, fillers, piercings, Botox injections, acupuncture or colonic irrigation?	
If YES, please give details Tell us if non sterile procedures were used	
Do you have any chronic infections?	
If YES, please give details	
Have you ever had a communicable disease, e.g. Herpes?	
If YES, please give details	
Have you ever had a history of a sexually transmitted infection?	
If YES, please give details	
In the last 12 months have you had close contact with another person with hepatitis?	
If YES, please give details	
In the last 12 months have you been treated for any infection?	
If YES, please give details	
Have you ever tested positive for HIV?	
If YES, please give details	

Question	Answer
Have you had routine childhood immunizations?	
If YES, please state which ones	
Have you had any recent vaccinations?	
If YES, please give details	
Have you been vaccinated against Hepatitis B?	
If YES, please give details, including approximate date of vaccination	
In the past 6 months, have you lived or travelled outside Europe, including Central America, Mexico or South America for a month or more?	
If YES, please give details	
In the past 12 months have you been bitten or scratched by *ANY* animal (including stray, domestic farm,wild or ticks), or have you been bitten by a human or been bitten by or in close contact with bats anywhere in the world?	
If YES, please give details	
Have you ever had any other serious infection such as Malaria, West Nile virus, typhoid fever, toxoplasmosis, rabies, encephalitis, Lyme disease or brucellosis?	
If YES, please give details	
Have you ever received Human Growth Hormone, fertility treatment or injections for hormone imbalance ?	
If YES, please give details	

NEUROLOGICAL/PSYCHOLOGICAL

Do you have a seizure disorder or epilepsy?	
If YES, please give details	
Have you ever had a stroke/transient ischaemic attack?	
If YES, please give details	
Have you been diagnosed with or investigated for any degenerative neurological diseases, e.g. dementia?	
If YES, please give details	
Have you ever had a diagnosis of or treatment for depression?	
If YES, please give details	
Have you ever had treatment for a mental health disorder?	
If YES, please give details	

CARDIOVASCULAR

Do you have a history of heart disease or chest pain?	
If YES, please give details	

Do you have or have you ever had high blood pressure?	
If YES, please give details	

Have you ever had a heart attack?	
If YES, please give details	

Have you ever had rheumatic fever or been told you have a heart murmur?	
If YES, please give details	

Have you ever had palpitations or been told you have an irregular heart rhythm?	
If YES, please give details	

HAEMATOLOGY/BLOOD DISORDERS

Do you and/or a family member have haemophilia or a clotting problem?	
If YES, please give details	

Have you ever received human derived clotting factor concentrates?	
If YES, please give details	

Have you or any of your family members had a problem with excessive bleeding?	
If YES, please give details	

Have you had excessive bleeding with any surgery or dental extractions?	
If YES, please give details	

Have you and/or a family member ever had a blood clot in your lungs or legs?	
If YES, please give details	

RESPIRATORY

Have you ever had any lung disease such as asthma or emphysema?	
If YES, please give details	

Have you ever been exposed to someone with tuberculosis or had a positive TB test?	
If YES, please give details	

Do you routinely use any inhalers or medications to help your breathing?	
If YES, please give details	

Have you ever been suspected of having Severe Acute Respiratory Syndrome (SARS) or been diagnosed with SARS?	
If YES, please give details	

Do you have sleep apnoea or use a CPAP machine?	
If YES, please give details	

GASTROINTESTINAL

Do you have any stomach or intestinal problems?	
If YES, please give details	

Have you ever had gallstones or gallbladder problems?	
If YES, please give details	

Have you ever had a colonoscopy or gastroscopy?	
If YES, please give details	

GENITOURINARY

Have you ever had any problems with your kidneys such as infections or stones?	
If YES, please give details	
Have you ever had any problems with your bladder such as infections, incontinence or difficulty in voiding?	
If YES, please give details	

FOR MEN ONLY

Do you have any problems related to an enlarged prostate?	
If YES, please give details	

FOR WOMEN ONLY

Have you ever had a gynaecological problem?	
If YES, please give details	
Did you ever experience a problem with pregnancy or delivery, or have you ever had a miscarriage?	
If YES, please give details	

Are you taking or have you taken any Hormone Replacement Therapy?	
If YES, please give details	
Date of last menstrual period:	
Date of last cervical smear:	
Date of last breast exam or mammogram:	

ENDOCRINE

Do you have diabetes?	
If YES, please give details, including type, date of onset	
Do you have a family history of diabetes?	
If YES, please give details, including which relative.	
Have you ever had increased blood sugars eg during pregnancy?	
If YES, please give details	

Have you ever been diagnosed with thyroid disease?	
If YES, please give details	

SOCIAL

Does your family have a history of any serious health issues, e.g. heart disease or stroke?	
If YES, please give details	
Are you the sole wage earner in your household?	
If YES, please give details, including which relative.	
Donating part of your liver requires approximately 4-12 weeks off work to recover. Do you think you will be able to take time off work?	

OTHER

Is there any other health information that we should know about?	
If YES, please give details,	
Having answered all questions about medical conditions and behavioural risk factors is there any reason why you think you should not be an organ donor?	

DECLARATION

Please tick this box to indicate you give the live donor team permission to contact your GP prior to seeing you in clinic	
Date	
Please tick this box to confirm these answers are correct to the best of your knowledge, and you agree to be contacted by the Live Donor Team	

OFFICE USE ONLY

Person administering questionnaire	
Date received	
Date reviewed	