TRANSPLANT QUÉBEC

# DONOR PHYSICAL EXAM

**Physical exam done by :** _____
Physician / Resident's name in print letters

Unique identifier number

**Date and time of the exam :** _____ : _____
AAAA-MM-JJ hh:mm

| ASSESSMENT | YES | NO | If affirmative answer or if verification impossible, please submit necessary explanations |
|---|---|---|---|
| 1. Physical evidence of recent tattoo | ☐ | ☐ | |
| 2. Physical evidence of ear or body piercings | ☐ | ☐ | |
| 3. Physical evidence of non medical percutaneous drug use such as needle tracks (including an examination of tattoos as they may cover up needle tracks) | ☐ | ☐ | |
| 4. Lesion, infection or trauma at the eventual organ retrieval site | ☐ | ☐ | |
| 5. Presence of cutaneous spots (blue, purple, gray or black) consistent with Kaposi's Sarcoma or other malignancy | ☐ | ☐ | |
| 6. Unexplained jaundice, hepatomegaly or icterus | ☐ | ☐ | |
| 7. Unexplained disseminated lymphadenopathy (swollen lymph nodes) or mucocutaneous lesions | ☐ | ☐ | |
| 8. Masses suspicious of malignangy (abdominal, breast or other location) | ☐ | ☐ | |
| 9. Candidose buccale | ☐ | ☐ | |
| 10. Signs of sexually transmitted diseases such as genital ulcerative disease, herpes simplex, syphilis or chancroid (genital lesions) | ☐ | ☐ | |
| 11. For a male donor: physical evidence of anal intercourse including perianal condyloma | ☐ | ☐ | |
| 12. Physical evidence of sepsis (such as generalized rash) | ☐ | ☐ | |
| 13. Presence of marks consistent with recent smallpox immunization (large scab, eczema vaccinatum, generalized vesicular rash (generalized vaccinia), severely necrotic lesion consistent with vaccinia necrosum) | ☐ | ☐ | |
| 14. Identified ocular abnormality (e.g. jaundice, sore, tumor, corneal infection, corneal scarring consistent with vaccinial keratitis) | ☐ | ☐ | |

**Please complete the back of this document and ensure it is signed and dated.**

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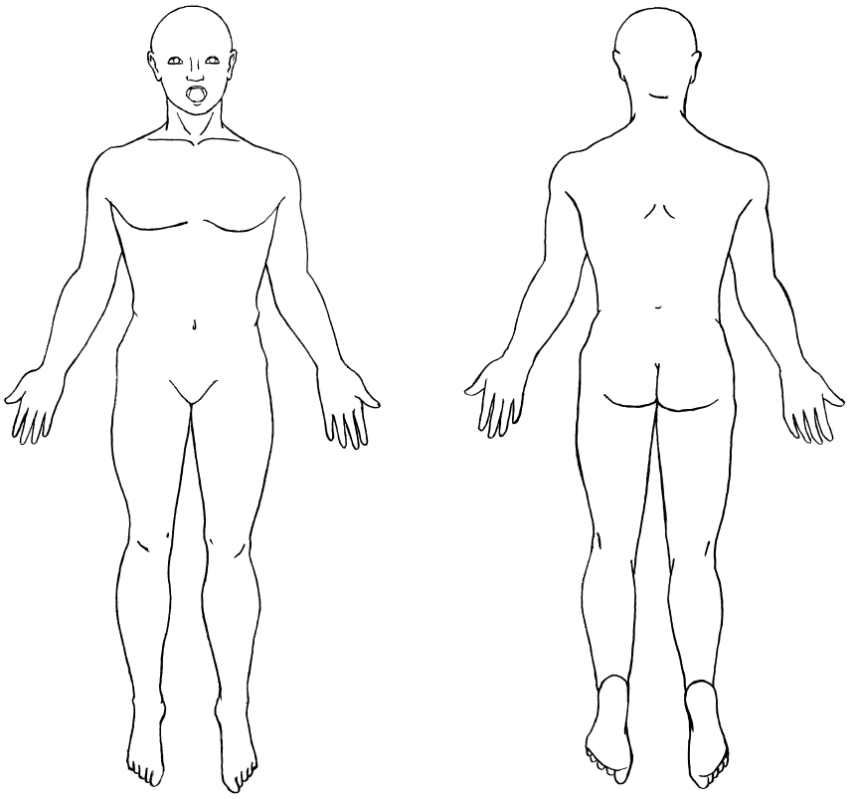
**Please complete the diagram below using the legend, if necessary.**



**Legend:**

| | |
|---|---|
| **A** | Abrasion |
| **B** | Burn |
| **BP** | Body piercing |
| **CE** | Contusion / Ecchymosis |
| **FX** | Fracture |
| **L** | Laceration |
| **M** | Mass |
| **NT** | Non-medical needle track |
| **OFX** | Open fracture |
| **PFX** | Penetrating fracture |
| **PW** | Profound wound |
| **SI** | Scar / Incision |
| **SR** | Skin rash |
| **T** | Tattoo |
| **VS** | Venipuncture site |
| **W** | Wound |
| **1** | _____ |
| **2** | _____ |
| **3** | _____ |
| **4** | _____ |
| **5** | _____ |

**Comments :** _____

_____

_____

_____

_____

**Exam done by :** _____ **Title :** _____
Physician / Resident's signature

**Hospital :** _____ **Date :** _____
YYYY-MM-DD

**Please submit this completed form to the clinical coordinator/advisor in charge of the case.**

**Regulatory conformity of this form verified by:** _____
Clinical coordinator/advisor's signature