TGLN ID #: _____

Complete this box for Paediatric Donors ONLY: ☐ Donor ☐ Maternal

Trillium Gift of Life Network
483 Bay Street South Tower, 4th Floor Toronto, Ontario M5G2C9
Telephone (24/7): 1.877.363.8456 Facsimile: 1.866.557.6100
Website: www.giftoflife.on.ca

Donor Medical and Social History Questionnaire

Donor Name: _____ **TGLN ID #:** _____

Name of Interviewee(s): _____

Relationship(s): _____

Address: _____

Donor's Address: ☐ Same as above, or: _____

Phone Number: _____

How long have you known him/her? _____

Before proceeding with organ and tissue donation, we need to ask you some questions (similar to those asked of blood donors) to gather information about any health or social risk factors that may be present. Certain parts of the questionnaire are sensitive, but the information is necessary to help determine whether there are diseases present that may be transmitted to the recipient. We ask that you answer all questions to the best of your knowledge. Answers will be kept strictly confidential (*see Privacy Note*).

Do you know him/her well enough to be able to answer questions about his/her medical history or social and relationship lifestyle? ☐ Yes ☐ No

If no, please provide the following information of the best person(s) to contact:

Name: _____ Relationship: _____

Phone Number: _____

Healthcare Professional who reviewed the donor's hospital medical record: ☐ N/A

Name: _____ Title: _____

Healthcare Professional who conducted the interview and completed the questionnaire:

Name: _____

Title: _____

Date of Interview: _____ Signature of Interviewer: _____

If the donation occurring is for Ocular Tissue only, it is necessary to complete the highlighted questions only.

Privacy Note: The personal information collected through this form is collected under the authority of *Gift of Life Act*, 2000. Trillium Gift of Life Network will use it for the purpose of determining suitability and other purposes related to organ and/or tissue donation and transplantation. If you have any questions regarding this collection, please contact: Trillium Gift of Life Network – Provincial Resource Centre: GTA: 416.363.4438, outside GTA: 1.877.363.8456.

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General Health Information			
1	What is the name and phone number of his/her family physician?	☐ No family MD	☐ Physician Information Provided as follows Physician's Name: Phone Number:
2	Was he/she born outside of Canada?	☐ No	☐ Yes ☐ Unknown If yes, where?
3	Has he/she been seen by a physician or been hospitalized (including psychiatric or long-term facility)?	☐ No	☐ Yes ☐ Unknown Please specify name of physician or facility, reason(s), and date(s):
4	Did he/she have any past major illness or surgical procedures?	☐ No	☐ Yes ☐ Unknown If yes, please specify and include date(s):
5	Did he/she have any history of cancer or malignancy including: • skin cancer, • myeloma, • leukemia, or • lymphoma?	☐ No	☐ Yes ☐ Unknown If yes, please specify type(s) and include date(s): Treatment: ☐ Radiation ☐ Chemotherapy ☐ Surgery Cancer-free interval (years): Last follow-up appointment (date, name of physician and hospital):
6	Did he/she suffer from any condition that may restrict his/her activities of daily living, such as: • shortness of breath or • chest pains?	☐ No	☐ Yes ☐ Unknown If yes, please explain:

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7	Did he/she have any physical limitations requiring assistive devices, such as a: • cane • walker, or • wheelchair?	☐ No	☐ Yes ☐ Unknown If yes, please explain:
8	Was he/she taking any medication prior to hospital admission?	☐ No	☐ Yes ☐ Unknown If yes, please specify drug, dose, and years (if known): ☐ See attached list
9	Did he/she have any allergies?	☐ No	☐ Yes ☐ Unknown If yes, please specify what the allergies are and if they are potentially life threatening:
10	Did he/she have extensive exposure to toxic substances, such as: • pesticides, • lead, • mercury, • asbestos, or • black mould?	☐ No	☐ Yes ☐ Unknown If yes, please specify substance(s), explain, and include date(s): Did he/she experience or have a diagnosis of any health problems as a result of exposure? ☐ No ☐ Yes If yes, please explain:
11	Did he/she have any history of diabetes (including gestational)?	☐ No	☐ Yes ☐ Unknown If yes, please specify: Duration (years): Was it treated? ☐ No ☐ Yes If yes, please specify treatment: ☐ Diet Controlled ☐ Medication(s): If yes, what type of medication? ☐ Oral medication(s): ☐ Insulin Injections (frequency/type): Did he/she ever use Bovine insulin after 1980? ☐ No ☐ Yes ☐ Unknown

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12	Did he/she have any history of kidney related disease, such as: • kidney stones, • infections, or • dialysis?	☐ No	☐ Yes ☐ Unknown If yes, please specify:
13	Did he/she have any history of high blood pressure (hypertension) or high cholesterol?	☐ No	☐ Yes ☐ Unknown If yes, please specify: Duration (years): Was it treated? ☐ No ☐ Yes If yes, please specify treatment: ☐ Diet Controlled ☐ Medication(s):
14	Did he/she ever receive CPR, or have a history of any heart disease, condition, or injury, such as: • rheumatic fever, • congenital heart disease, • coronary artery disease or previous coronary bypass surgery, • valvular disease, • bacterial or fungal endocarditis, • viral myocarditis, • Marfan's disease, • cardiomyopathy, • penetrating cardiac injury, or • chest pain?	☐ No	☐ Yes ☐ Unknown If yes, please specify and include date(s): Treatment:
15	Did he/she have any family history of • diabetes, • hypertension, • coronary artery disease, or • stroke?	☐ No	☐ Yes ☐ Unknown If yes, please specify: Relationship to donor:

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16	Did he/she have any history of circulatory problems of the arms and legs, such as: • varicose veins, • phlebitis, • vasculitis, • venous insufficiency, or • deep vein thrombosis?	☐ No	☐ Yes ☐ Unknown If yes, please specify:
17	Did he/she have any history of lung disease such as: • asthma, • emphysema, or • COPD?	☐ No	☐ Yes ☐ Unknown If yes, please specify: Required hospitalization? ☐ No ☐ Yes
18	Did he/she ever have any liver disease, including hepatitis, or jaundice?	☐ No	☐ Yes ☐ Unknown If yes, please explain: Diagnosis? Required hospitalization? ☐ No ☐ Yes
19	Did he/she have a colonoscopy or any history of digestive or intestinal problems, such as: • ulcerative colitis, • bloody stools, or • Crohn's Disease?	☐ No	☐ Yes ☐ Unknown If yes, please specify which problem and explain:
20	Did he/she have any history of neurological or brain disease, such as: • epilepsy • Alzheimer's, • dementia, • stroke, • Parkinson's, • encephalitis, • meningitis, • any prion-related disease, such as Creutzfeldt-Jakob disease (CJD or any form of mad cow disease), or • any family history of CJD, Parkinson's, or dementia?	☐ No	☐ Yes ☐ Unknown If yes, please specify: If yes, for family history, please specify relationship to donor and diagnosis:
21	Did he/she recently experience any of the following symptoms: • memory loss, • seizures, • confusion, • spontaneous rippling or twitching of muscle, • unsteady gait, or • speech problems?	☐ No	☐ Yes ☐ Unknown If yes, please specify:

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22	Did he/she recently experience symptoms such as: • headaches, • drowsiness, • neck stiffness, • loss of vision, • sensitivity to light, or • any unexplained neurological problems?	☐ No	☐ Yes ☐ Unknown If yes, please specify:
23	Was he/she ever diagnosed with or investigated for any autoimmune or chronic degenerative disorder, such as: • ALS (Lou Gehrig's disease), • Multiple Sclerosis (MS), • rheumatoid arthritis, • systemic lupus erythematosis (lupus), • polyarteritis nodosa, • thyroid disease, • sarcoidosis, or • myasthenia gravis?	☐ No	☐ Yes ☐ Unknown If yes, please specify: Treatment:
24	Did he/she have any bone or joint disease, such as: • osteoporosis, • arthritis, • osteomyelitis, or • metabolic bone disease, such as osteomalacia?	☐ No	☐ Yes ☐ Unknown If yes, please specify: Treatment: If arthritis, type: Location:
25	Did he/she experience any periods of unexplained weight loss or have any blue or purple spots on the skin or mucous membrane?	☐ No	☐ Yes ☐ Unknown If yes, please explain:
26	Did he/she have any history of skin conditions or disease, such as: • infection, • eczema, • dermatitis, • leprosy, • inflammatory skin diseases • abrasions, or • sores in the mouth or on the skin?	☐ No	☐ Yes ☐ Unknown If yes, please specify:

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Blood / Blood Products / Tissues			
27	Did he/she ever receive a transfusion of blood or blood products?	☐ No	☐ Yes ☐ Unknown If yes, please specify type(s) and include date(s)? In what country(s):
28	Did he/she ever use or take human-derived pituitary growth hormones?	☐ No	☐ Yes ☐ Unknown If yes, when was it used? What kind was it? In what country(s)?
29	Was he/she ever refused as a blood donor or told not to donate blood?	☐ No	☐ Yes ☐ Unknown If yes, why?
30	Did he/she ever receive an organ or tissue transplant, such as a: • kidney, • dura mater, • cornea, • bone, • skin, or • heart valve?	☐ No	☐ Yes ☐ Unknown If yes, please specify type(s), date(s), and include any complications:
31	Did he/she ever have a transplant or medical procedure that involved live cells, tissues or organs from an animal?	☐ No	☐ Yes ☐ Unknown If yes, please specify and include date(s):

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Infections / Infectious Diseases			
32	In the past 12 months, has he/she been investigated, diagnosed, or treated for any type of infection, such as: • Epstein Barr Virus (EBV), • Cytomegalovirus (CMV), or • Toxoplasmosis?	☐ No	☐ Yes ☐ Unknown If yes, please explain and include date(s): Treatment:
33	Has he/she ever been quarantined, investigated, diagnosed, or treated for an emerging infectious disease (e.g., Tuberculosis, Zika, MERS or Ebola)?	☐ No	☐ Yes ☐ Unknown If yes, please explain and include date(s): Treatment:
34	Has he/she ever had direct contact or exposure to a place or person who is known or suspected to have an emerging infectious disease (e.g. Tuberculosis, Zika, MERS or Ebola)?	☐ No	☐ Yes ☐ Unknown If yes, please explain:
35	In the last 3 weeks, has he/she or any family member living in the immediate household had any symptoms, such as: • unexplained weakness or fatigue, • persistent or frequent cough, • swollen lymph nodes, • nausea or vomiting, • persistent diarrhea, • fever over 38°C with headache, • any fever, • any headache, • rash, • joint pain, • conjunctivitis (red/pink eye), • night sweats, • muscle aches, or • shortness of breath?	☐ No	☐ Yes ☐ Unknown If yes, please specify:
36	Has he/she ever been told by a health professional that they were suspected or known to have West Nile Virus, based on symptoms, exposure to, or a positive test for West Nile Virus within the last 120 days?	☐ No	☐ Yes ☐ Unknown If yes, please explain and include date(s):

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37	Has he/she been bitten by an animal in the past year?	☐ No	☐ Yes ☐ Unknown If yes, please explain: Was there any concern or treatment for rabies? ☐ No ☐ Yes
38	Did he/she ever have contact* with a bat or bats? *contact defined as history of a bat inside the living area or been bitten or scratched by a bat.	☐ No	☐ Yes ☐ Unknown If yes, please explain: Was there any concern or treatment for rabies? ☐ No ☐ Yes
39	Has he/she ever had a positive skin test for, been diagnosed with, or ever been treated for tuberculosis?	☐ No	☐ Yes ☐ Unknown If yes, please explain and include date(s): Did he/she receive any vaccines for tuberculosis/BCG? ☐ Yes ☐ No ☐ Unknown
40	In the past 12 months, did he/she have any vaccinations or immunizations? (e.g., Shingles, Chickenpox, MMR, Yellow fever, BCG, Oral typhoid, Smallpox)	☐ No	☐ Yes ☐ Unknown If yes, please specify and include date(s):
41	Did he/she know anyone who had a smallpox vaccination?	☐ No	☐ Yes ☐ Unknown If yes, was that person vaccinated within the past two months? ☐ No ☐ Yes If yes, did he/she have contact with this person which includes touching the vaccination site, handling bandages that covered it, or handling bedding, clothing, or any other material that came in contact with the vaccination site? ☐ No ☐ Yes If yes, did he/she experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? ☐ No ☐ Yes

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			If yes, please provide details:
42	In the past 12 months, has he/she been exposed to any blood or body fluids known or suspected to be contaminated by HIV, HTLV, or Hepatitis B or C? (Possible routes of transmission may include accidental needle stick, contact with open wounds or non-intact skin, and mucous membranes.)	☐ No	☐ Yes ☐ Unknown If yes, please specify:
43	Did he/she ever have a positive test for Hepatitis B or C?	☐ No	☐ Yes ☐ Unknown If yes, please specify and include date(s): Did he/she ever receive treatment for Hepatitis C? ☐ No ☐ Yes ☐ Unknown If yes, please specify and include date(s):
44	In the past 12 months, did he/she have close contact with anyone having clinically active HBV or clinically active HCV infection? Close contact is defined as repeatedly and regularly sharing the same living space with someone.	☐ No	☐ Yes ☐ Unknown If yes, what type of hepatitis did that person have?
45	Was he/she ever tested for or diagnosed with HIV or HTLV?	☐ No	☐ Yes ☐ Unknown If yes or unknown, please specify: Why was he/she tested? Results: Treatment:

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46	Has he/she ever had a travel-related disease such as: • Malaria, • Chagas Disease, • Babesiosis, • Leishmaniasis, or • Zika?	☐ No	☐ Yes ☐ Unknown If yes, please specify and include date(s):
47	Did he/she ever receive immunization or treatment, including preventative, for a travel-related disease?	☐ No	☐ Yes ☐ Unknown If yes, please explain and include date(s): Treatment:
Eye Donors: If donating eyes, complete the following questions. If no, select N/A for questions 48 and 49.			
48	Did he/she ever have any of the following: • eye disorder, • eye infection, • previous eye surgery (including laser surgery), • glaucoma, • cataracts, • corneal disease, • eye tumors such as retinoblastoma or pterygium, or • any other eye disorders including infection or inflammation?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, please specify and include date(s): Treatment: Name of Ophthalmologist:
49	Was he/she ever treated for congenital Rubella or Reyes Syndrome?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, specify:

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Lifestyle			
50	Did he/she ever smoke tobacco products, marijuana or vape (inhale vapors produced by an electronic device?	☐ No	☐ Yes ☐ Unknown If yes, type: Frequency and quantity per day and/or week: Years of use: Quit: ☐ No ☐ Yes If yes, how many years ago?

51	Did he/she drink alcohol?	☐ No	☐ Yes ☐ Unknown If yes, type: Amount and Frequency: Years of use: Quit: ☐ No ☐ Yes If yes, how many years ago?

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52	Did he/she ever use or take drugs, such as: • marijuana, • steroids, • cocaine, • amphetamines, • anything not prescribed by his/her doctor, or • overuse of medication prescribed by his/her doctor?	☐ No	☐ Yes ☐ Unknown If yes, please specify: Were needles used? ☐ No ☐ Yes Were recreational or non-prescribed drugs used intranasally? ☐ No ☐ Yes If not needles or intranasally, indicate how used: How often and how long was it used? When was it last used? Quit: ☐ No ☐ Yes If yes, how many years ago?
53	In the past 12 months, did he/she have tattooing, ear/body piercing, electrolysis, acupuncture, or permanent make-up?	☐ No	☐ Yes ☐ Unknown If yes, which one(s)? ☐ Tattooing ☐ Ear/Body Piercing ☐ Electrolysis ☐ Acupuncture ☐ Permanent Make-up Was the tattooing, ear/body piercing, electrolysis, acupuncture, or permanent make-up done under non-sterile conditions, with shared instruments, contaminated ink, and/or where sterility of the procedure was unknown? ☐ No ☐ Yes In what country? Name and Location of Service Provider: Date: By whom?

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54	Was he/she ever in a youth correctional facility, jail, lockup or prison?	☐ No	☐ Yes ☐ Unknown If yes, when? _____ Where? _____ Duration: _____
55	Did he/she ever experience homelessness or live in a homeless shelter?	☐ No	☐ Yes ☐ Unknown If yes, when? _____ For how long? _____

Sexual History

As a reminder, the following questions are of a sensitive and personal nature. These questions are required to be asked of all potential donors. The following questions pertain to his/her sexual history. Sexual activity and sex refer to any method of sexual contact including vaginal, anal, and oral.

56	In the past 12 months, did he/she have any sexually transmitted diseases, such as: • syphilis, • gonorrhea, • genital herpes, • genital warts, or • HPV?	☐ No	☐ Yes ☐ Unknown If yes, please specify: _____ Did he/she receive treatment? ☐ No ☐ Yes If yes, please specify date: _____
57	Did he/she ever live with or have sex with anyone who received an organ or tissue transplant from an animal?	☐ No	☐ Yes ☐ Unknown If yes, when? _____
58	Did he/she ever live with or have sex with anyone who was born in or who lived in Africa after 1977?	☐ No	☐ Yes ☐ Unknown If yes, which country(s)? _____
59	In the past 5 years, has he/she been a victim of sexual assault or rape?	☐ No	☐ Yes ☐ Unknown If yes, complete Questions **60** to **70** below. If No or Unknown, complete questions **60** below.
60	In the past 5 years, has he/she been sexually active even once?	☐ No	☐ Yes ☐ Unknown If yes, complete Questions **61** to **70** below. If No or Unknown, select N/A for questions **61** to **70**.

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61	In the past 5 years, did he/she have sex in exchange for money or drugs?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, when?
62	**Male Donors Only:** In the past 5 years, did he have sex with another male?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, did sex occur in the past 12 months? ☐ No ☐ Yes ☐ Unknown Provides dates, if known:
63	In the past 12 months, did he/she have sex with a person who has (a) had male to male sexual relations in the past 5 years or (b) whose sexual partner has had male to male sexual relations in the past 5 years?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, (a) was the male to male sexual relations in the past 12 months OR (b) did the sexual partner have male to male sexual relations in the past 12 months? ☐ No ☐ Yes ☐ Unknown Please explain and provides dates, if known:
64	In the past 12 months, did he/she have sex with a person who has had sex in exchange for money or drugs in the past 5 years?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, when?
65	In the past 12 months, did he/she ever have sex with a person who used a needle to inject drugs that were not prescribed by their own doctor in the past 5 years?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, when?
66	In the past 12 months, did he/she have sex with any person known or suspected to have HIV, HTLV, or Hepatitis B or C?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, which virus and when? Was that person sick from the virus during that time, including exhibiting symptoms, such as: abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin? ☐ No ☐ Yes

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67	In the past 12 months, did he/she have sex with a person who has been exposed to any blood or body fluids known or suspected to be contaminated by HIV, HTLV, or Hepatitis B or C? (Possible routes of transmission may include accidental needle stick, contact with open wounds or non-intact skin, and mucous membranes.)	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, when?
68	In the past 12 months, did he/she have sex with any person known to have hemophilia or other clotting disorders that required transfusion of blood or blood products such as human derived clotting factor concentrates?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, what was it and when was it used?
69	In the past 12 months, did he/she have a sexual partner whose sexual background was unknown?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, when?
70	In the last 21 days, has he/she had sexual contact with a man who is known to have either: a) A known, or suspected medical diagnosis of Zika Virus infection within six months prior to the sexual contact, **OR** b) Resided in, or travelled to an area with active Zika Virus transmission within the past 6 months	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, please explain:
Travel			
71	Travel History: Ask all three parts of the question (71a, 71b and 71c), and further subquestions as required 71a. Did he/she travel/live outside of Ontario and/or outside of Canada in the past six months?	☐ No	☐ Yes ☐ Unknown If yes, please provide details specifying where, date(s) and duration(s): Travelled in the preceding 56 days to areas where WNV is endemic ☐ No ☐ Yes ☐ Unknown

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	71b. Did he/she spend a COMBINED TOTAL of more than one month outside Canada?	☐ No	☐ Yes ☐ Unknown If yes, specify if any of the following apply and provide details below: Rural Mexico and/or Central America and/or South America (for a combined duration up to 3 months or more) ☐ Lived in ☐ Travelled to ☐ N/A United Kingdom (England, Northern Ireland, Scotland, Wales, Isle of Man or Channel Islands) and/or France (for a combined duration of 3 months or more between January 1, 1980 to December 31, 1996) ☐ Lived in ☐ Travelled to ☐ N/A Europe including the United Kingdom or France (for a combined duration of 5 years or more since January 1, 1980) ☐ Lived in ☐ Travelled to ☐ N/A Travel/live anywhere else not mentioned above? ☐ No ☐ Yes ☐ Unknown Please provide details to any of the above or other locations, specifying where, date(s) and duration(s):
	71c. Did he/she ever live on a military base outside Canada?	☐ No	☐ Yes ☐ Unknown Please provide details specifying where, which country's military, date(s) and duration(s):
72	In the last year, has he/she travelled to an area or been in contact with someone who has travelled to a location listed on a travel advisory for communicable disease?	☐ No	☐ Yes ☐ Unknown If yes, please specify location(s), time period of travel, and reason for advisory:

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Paediatric Donors: If the donor is 18 years old or greater, select N/A for Questions 73 to 77			
73	Was the child born to a mother who had or was at risk for HIV or hepatitis infection?	☐ No ☐ N/A	☐ Yes ☐ Unknown
If the child is less than 11 years old, complete Questions **74** to **77** below If not applicable, select N/A for Questions **74** to **77**			
74	In the past 12 months, was the child breast-fed or did they receive breast milk?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, Maternal Medical and Social History Questionnaire and Serology must be completed.
75	Was the child less than or equal to 18 months of age?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, Maternal Medical and Social History Questionnaire and Serology must be completed.
76	Did the mother receive any type of pre-natal care?	☐ No ☐ N/A	☐ Yes ☐ Unknown If yes, please describe:
77	How would you describe the mother's health during the pregnancy?	☐ N/A	☐ Provided as follows Describe:
All Donors			
78	Are you aware of any other medical conditions that we have not discussed?	☐ No	☐ Yes If yes, please specify:
79	After completing this questionnaire, is there any reason to believe that the donated organs and/or tissues may not be suitable or safe for transplantation?	☐ No	☐ Yes If yes, please specify:
80	Are there any other individuals that may provide more personal or additional information regarding any of these questions?	☐ No	☐ Yes If yes, please provide the following information: ☐ Same as Page 1 ☐ Provided as follows Name: Relationship: Phone Number:

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81	Have funeral arrangements been made or do you know which funeral home you will be using?	☐ No	☐ Yes ☐ Unknown at this time If yes, Funeral Home: Contact Name: Phone Number: Address: Additional Family Requests (e.g., viewing body after recovery surgery):

Additional Comments