Eye-Only Donor Risk Assessment Interview (Donor >10 yrs old)

483 Bay Street South Tower,
4th Floor
Toronto, Ontario M5G2C9
Tel (24/7): 1.888.603.1399
Fax: 1.866.557.6100
Website: www.giftoflife.on.ca

Donor Name: ____
First Middle Last

Person Interviewed: ____
Name Relationship

Contact Information: __(____)____
Phone Address City State Zip

The interview was conducted: by telephone ❑ in person ❑

Person Interviewed: ____
Name Relationship

Contact Information: __(____)_____________ ____
Phone Address City State Zip

The interview was conducted: by telephone ❑ in person ❑

Person conducting interview and completing this form:

____
Print Name Signature Date/Time

I want to advise you of the sensitive and personal nature of some of these questions. They are similar to those asked when someone donates blood. We ask these questions for the health of those who may receive her/his* gift of donation. I will read each question and you will need to answer to the best of your knowledge with a "Yes" or "No."

A1. How long have you known him/her?		(blank field to enter in period of time)

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B1. In the past **12 months**, was she/he* investigated, diagnosed or treated for any type of infection?	❑No ❑Yes	(i) What type of infection? (ii) Date and duration? (iii) Treatment?
B2. Was he/she* **EVER** quarantined, investigated, diagnosed, or treated for a potentially communicable illness (e.g. Influenza A, SARS, or Ebola)?	❑No ❑Yes	(i). Please explain and include date(s): (ii) Treatment?
B3. Did he/she* **EVER** have direct contact or exposure to a place or person who is known or suspected to have a potentially communicable illness (e.g. Influenza A, SARS, Ebola)?	❑No ❑Yes	Please explain:

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4a. Did she/he* have a family physician or a specialist?	❑No ❑Yes	4a(i). When was her/his* last visit? 4a(ii). Why? 4a(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):
4b. Did she/he* use a medical facility such as a clinic or urgent care center?	❑No ❑Yes	4b(i). When was her/his* last visit? 4b(ii). Why? 4b(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):

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5a. Did she/he* take any prescription medication recently or on a regular basis?	❑No ❑Yes	5a(i). What was it and/or what was it used for?
5b. Did she/he* take any non-prescribed medication or dietary supplements?	❑No ❑Yes	5b(i). What was it and/or what was it used for?
6. Did she/he* recently have any symptoms such as:		*If any answer in question 6. is "yes,"* ask "when" *this occurred* ***and*** "describe symptoms and reasons," *if known.*
6a. a fever?	❑No ❑Yes	6a(i). When? 6a(ii). Describe the fever and reasons.
6b. cough?	❑No ❑Yes	6b(i). When? 6b(ii). Describe the cough and reasons.
6c. diarrhea?	❑No ❑Yes	6c(i). When? 6c(ii). Describe diarrhea and reasons.
6d. swollen lymph nodes or glands in the neck, armpits or groin?	❑No ❑Yes	6d(i). When? 6d(ii). Describe swollen lymph nodes or glands and reasons.
6e. weight loss?	❑No ❑Yes	6e(i). When? 6e(ii). Describe how much weight loss and reason(s).
6f. a rash?	❑No ❑Yes	6f(i). When? 6f(ii). Describe the rash and reasons.

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6g. sores in the mouth or on the skin?	❑No ❑Yes	6g(i). When? 6g(ii). Describe the sores and reasons.
6h. night sweats?	❑No ❑Yes	6h(i). When? 6h(ii). Describe night sweats and reasons.
6i. severe headache?	❑No ❑Yes	6i(i). When? 6i(ii). Describe the severe headache and reasons.
6j. rapid decline in mental ability?	❑No ❑Yes	6j(i). When? 6j(ii). Describe rapid decline in mental ability and reasons.
6k. seizures?	❑No ❑Yes	6k(i). When? 6k(ii). Describe seizures and reasons.
6l. tremors?	❑No ❑Yes	6l(i). When? 6l(ii). Describe tremors and reasons.
6m. difficulty walking?	❑No ❑Yes	6m(i). When? 6m(ii). Describe difficulty walking and reasons.

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8. Did she/he* know anyone who had a smallpox vaccination?	❑No ❑Yes	8a. Was **that person** vaccinated within the past two months? ❑No ❑Yes *If yes,* 8a(i). Did she/he* have contact with this person which includes touching the vaccination site, handling bandages that cover it, or handling bedding, clothing, or any other material that came in contact with the vaccination site? ❑No ❑Yes *If yes,* 8a(i)a. Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? ❑No ❑Yes *If yes,* 8a(i)a(i). Explain:
9. In the past **12 months** was she/he* in lockup, jail, prison, or any juvenile correctional facility?	❑No ❑Yes	9a. How long?
10. In the past **12 months** was she/he* bitten or scratched by any pet, stray, farm, or wild animal?	❑No ❑Yes	10a. What kind of animal? 10b. When? 10c. Did she/he* receive any medical treatment? ❑No ❑Yes *If yes,* 10c(i). By whom? 10d. Was the animal suspected of having rabies? ❑No ❑Yes 10e. Was the animal quarantined or tested? ❑No ❑Yes 10e(i). Which one? *If yes to tested,* 10e(ii). What was the result?

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11. In the past **12 months** was she/he* told by a healthcare professional that they had a West Nile virus infection?	❑No ❑Yes	11a. When was she/he* diagnosed? *If this occurred within the past 4 months ask:* 11a(i). What was the name of the doctor/clinic?
12. In the past **12 months** did she/he* have any shots or immunizations, such as for the flu, MMR, yellow fever, hepatitis B, etc.?	❑No ❑Yes	12a. When? 12b. What kind was it? *If smallpox/vaccinia is named, ask these questions:* 12b(i). Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? ❑No ❑Yes *If yes,* 12b(i)a. When did these symptoms resolve? 12b(ii). Did the scab fall off or was it picked off? 12b(ii)a. When?
This is a reminder these are standard questions we ask in every interview. Answer to the best of your knowledge with a "Yes" or "No."		
13. In the past **12 months** did she/he* get a tattoo, touch up of an old tattoo, or permanent makeup?	❑No ❑Yes	13a. Were shared or non-sterile instruments, needles or ink used? ❑No ❑Yes
14. In the past **12 months** did she/he* have acupuncture, ear or body piercing?	❑No ❑Yes	14a. Were shared or non-sterile instruments or needles used? ❑No ❑Yes
15a. In the past **12 months** did she/he* live with a person who has hepatitis?	❑No ❑Yes	15a(i). What type of hepatitis did **that person** have? 15a(ii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin? ❑No ❑Yes

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16. In the past **12 months** did she/he* come into contact with someone else's blood?	❑No ❑Yes	16a. Describe what happened and when: 16b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis? ❑No ❑Yes
17. In the past **12 months** did she/he* have an accidental needle-stick?	❑No ❑Yes	17a. Describe what happened and when: 17b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis? ❑No ❑Yes
As I described before, I want to remind you of the sensitive and personal nature of some of these questions. For medical and health reasons, we are required to ask these questions about all potential donors. Next, I will ask you about her/his* sexual history.		
18. In the past **12 months** did she/he* have a sexually transmitted infection such as syphilis, gonorrhea, chlamydia, or genital ulcers, herpes, or genital warts?	❑No ❑Yes	18a. What was it?

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For the next part, sexual activity and sex refer to any method of sexual contact including vaginal, anal, and oral.

I will read each question and you should answer to the best of your knowledge with a "Yes" or "No."

19. In the past **5 years** was she/he* sexually active, even once?	❑No ❑Yes	*If yes, complete the following questions (19a. to 19g.)* **For the following set of questions, think about the past 5 years:** 19a. Did she/he* have sex in exchange for money or drugs? ❑No ❑Yes *If yes,* 19a(i). When? 19b. **MALE DONOR only:** Did he have sex with another male? ❑ (N/A) Donor is Female ❑No ❑Yes *If yes,* 19b(i). When? 19c. Did she/he* have sex with a person who has had sex in exchange for money or drugs? ❑No ❑Yes *If yes,* 19c(i). When? 19d. **FEMALE DONOR only:** Did she have sex with a male who had sex with another male? ❑ (N/A) Donor is Male ❑No ❑Yes *If yes,* 19d(i). When? 19e. Did she/he* have sex with a person who used a needle to inject drugs that were not prescribed by their own doctor? ❑No ❑Yes *If yes,* 19e(i). When?

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		19g. Did she/he* have sex with a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV? ❑No ❑Yes *If yes,* 19g(i). Which virus and when? 19g(ii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin? ❑No ❑Yes
21. Did she/he* **EVER** use or take drugs, such as steroids, cocaine, heroin, amphetamines, or anything **NOT** prescribed by her/his* doctor?	❑No ❑Yes	21a. What was it? 21c. When was it last used? 21d. Were needles used? ❑No ❑Yes *If no,* 21d(i). How was it taken?
22a. Did she/he* **EVER** have a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal? **22b.** Did she/he* live with, or have sex with, a person who had?	❑No ❑Yes ❑No ❑Yes	22a(i). Explain: 22b(i). Explain:

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23. Was she/he* **EVER** told by a physician that she/he* had a disease of the brain or a neurological disease such as Alzheimer's, Parkinson's, multiple sclerosis, or epilepsy?	❑No ❑Yes	23a. What was she/he* told by a physician?
25. Did she/he* **EVER** have any kind of surgery?	❑No ❑Yes	25a. What kind? 25b. Where? 25c. When?
26. Did she/he* **EVER** travel or live outside of the United States or Canada?	❑No ❑Yes	26a. Where? 26b. When and for how long? 26c. Did she/he* **EVER** receive a blood transfusion or other medical treatment outside of the United States or Canada? ❑No ❑Yes *If yes,* 26c(i). What occurred (which one)? 26c(ii). Describe where and when: *If international travel or residency is extensive, be aware of query regarding vaccinations or other shots (within the past 12 months) at question #12.*

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27. Was she/he* **EVER** a U.S. military member, a civilian military employee, or a dependent of either?	❑No ❑Yes	27a. Did she/he* ever live or work on a U.S. military base outside the United States? ❑No ❑Yes *If yes,* 27a(i). In which country or countries? 27a(ii). When? *If this occurred between 1980 and 1996 in Europe:* 27a(ii)a. How long? *(estimate total time)* *If in the military in the past 12 months, be aware of query regarding vaccinations or other shots at question #12.*
28. Did she/he* **EVER** use or take growth hormone?	❑No ❑Yes	28a. When was it used? 28b. What kind was it?
29. Did she/he* **EVER** have a positive or reactive test for:		
29a. the HIV/AIDS virus?	❑No ❑Yes	29a(i). Explain:
29b. hepatitis?	❑No ❑Yes	29b(i). Explain:
29c. HTLV-I or HTLV-II?	❑No ❑Yes	29c(i). Explain:
30. Did she/he* **EVER** have liver disease or hepatitis?	❑No ❑Yes	30a. What kind? 30b. When?

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32. Did she/he* **EVER** have cancer?	❑No ❑Yes	32a. What type? 32b. When was it diagnosed? 32c. Describe when and where surgery, radiation, or chemotherapy occurred: 32d. Was the cancer considered cured? ❑No ❑Yes *If yes,* 32d(i). When?
36. Did she/he* EVER have diabetes?	❑No ❑Yes	36a. For how many years? 36b. Was it treated? ❑No ❑Yes *If yes,* 36b(i). How?
42. Did she/he* **EVER** have any eye problems, procedures, or surgery?	❑No ❑Yes	*If yes to eye problems:* 42a. What kind of eye problems? *If yes to eye surgery or procedures:* 42b. What kind of surgery or procedure was performed and why? 42c. Which eye(s)? ❑ left ❑ right ❑ unknown 42d. What is the name and/or phone number of her/his* eye doctor or eye clinic?

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43. Did she/he* or **any** of her/his* relatives have Creutzfeldt-Jakob disease, which is also called CJD or variant CJD?	❑No ❑Yes	43a. Who did? *If a relative,* 43a(i). Is this person a blood relative? *(Note: The definition of blood relative is a person who is related through a common ancestor and not by marriage or adoption)* ❑No ❑Yes *If yes,* 43a(i)a. Which blood relative? 43b. Is there a physician, relative, or other person who can provide more information? *(document discussion)*
FINAL QUESTIONS		
45. Are there other medical conditions you are aware of that we have not discussed?	❑No ❑Yes	45a. Describe:
46. Do you now have any concerns that her/his* donation should not proceed?	❑No ❑Yes	46a. Can you share your concerns?
47. Regarding these questions, are there other people, including healthcare professionals, who may provide additional information?	❑No ❑Yes	47a. Name(s) and contact information:
48. Do you have any questions about these questions?	❑No ❑Yes	48a. Document:

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D1. Have funeral or final resting place arrangements been made?	❑No ❑Yes	(i). Which funeral home (or equivalent) did you make the arrangements with? (ii). Name(s) and contact information: (iii). May we contact the funeral home to notify them of the donation and recovery timelines?
Note to Interviewer: Question below must be asked if Question 36 was answered "yes". **Check here if question skipped ❑.**		
E1. Did she/he* **EVER** have complications from diabetes:	❑No ❑Yes	If yes, complete the following questions: Diabetic nerve pain or numbness in the feet, legs or hands ❑No ❑Yes If yes, (i). When? (ii). How long in duration? (iii). Was it treated? If yes, how? Circulation problems in the feet, legs or hands ❑No ❑Yes If yes, (i). When? (ii). How long in duration? (iii). Was it treated? If yes, how? Diabetes related amputation ❑No ❑Yes If yes, (i). When? (ii). How long in duration? (iii). Was it treated? If yes, how? Diabetic kidney disease ❑No ❑Yes

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		If yes, (i). When? (ii). How long in duration? (iii). Was it treated? If yes, how? Vision problems from diabetes ❑No ❑Yes If yes, (i). When? (ii). How long in duration? (iii). Was it treated? If yes, how? Other complications from diabetes ❑No ❑Yes If yes, (i). When? (ii). How long in duration? (iii). Was it treated? If yes, how?

ADDITIONAL NOTES

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