Trillium Gift of Life Network

Eye-Only Donor Risk Assessment Interview
Child Donor ≤10 years old

CSF-9-215
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 know 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?

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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:
1. What was her/his* date of birth?	*Date of Birth:* _____ *Interviewer calculates the donor's age:* _____ • *If ≤18 months old, complete the RAI (Birth Mother) in addition to this form.* • *If <5 years old, ask question 1a:* 1a. Within the past 12 months, was she/he* breastfed or was she/he* fed breast milk from another person? ❑No ❑Yes *If yes, ask:* 1a(i). Who provided the breast milk?_____ • *If this is the birth mother, complete the DRAI (Birth Mother) in addition to this form.* *Check which DRAI form(s) will be completed:* ❑ *DRAI (Child Donor ≤10 years old)* ❑ *DRAI (Birth Mother)*	
3. Did she/he* have any illnesses or ongoing problems with health, such as:		*If any answer in question 3. is "yes," further questioning is required.*

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3c. a disease of the brain or a neurological disease?	❑No ❑Yes	3c(i). Explain:
3d. diabetes?	❑No ❑Yes	3d(i). For how many years? _____ 3d(ii). Was it treated? ❑No ❑Yes *If yes,* 3d(ii)a. How?
4a. Did she/he* have a pediatrician, a family physician, or a specialist?	❑No ❑Yes	4a(i). When was her/his* last visit? 4a(ii). Why? 4a(iii). Who do they see or where do they go? *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). Who do they see or where do they go? *Provide any contact information (e.g., name, group, facility, phone number, etc.):*
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?

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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.
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.

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6i. severe headache?	❑No ❑Yes	6i(i). When? 6i(ii). Describe the severe headache and reasons.
6j. rapid decline in <u>mental</u> functions, such as behaving differently than normal?	❑No ❑Yes	6j(i). When? 6j(ii). Describe rapid decline in mental functions and reasons.
6k. rapid decline in <u>physical</u> functions, such as moving differently than normal?	❑No ❑Yes	6k(i). When? 6k(ii). Describe decline in physical functions and reasons.
7. Did she/he* have contact with anyone who had a smallpox vaccination?	❑No ❑Yes	7a. Was **that person** vaccinated within the past 2 months? ❑No ❑Yes *If yes,* 7a(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,* 7a(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,* 7a(i)a(i). Explain:

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8. Was she/he* **EVER** bitten or scratched by any pet, stray, farm, or wild animal?	❑No ❑Yes	8a. What kind of animal? 8b. When? 8c. Did she/he* receive any medical treatment? ❑No ❑Yes *If yes,* 8c(i). By whom? 8d. Was the animal suspected of having rabies? ❑No ❑Yes 8e. Was the animal quarantined or tested? ❑No ❑Yes 8e(i). Which one? *If yes to tested,* 8e(ii). What was the result?
9. Were you **EVER** told by a healthcare professional that she/he* had a West Nile virus infection?	❑No ❑Yes	9a. When was she/he* diagnosed? *If this occurred within the past 4 months ask:* 9a(i). What was the name of the doctor/clinic?
10. Did she/he* have any shots or immunizations, such as for the flu, MMR, chickenpox, rotavirus, etc.?	❑No ❑Yes	10a. When was the last time? 10b. What kind was it? *<u>If smallpox/vaccinia is named</u>, ask these questions:* 10b(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,* 10b(i)a. When did these symptoms resolve? 10b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>? 10b(ii)a. When?

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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."		
11. Did she/he* **EVER** get a tattoo?	❑No ❑Yes	11a. When? *If in the past 12 months, ask these questions:* 11b. Were shared or non-sterile instruments, needles or ink used? ❑No ❑Yes
12. Did she/he* **EVER** have acupuncture, ear or body piercing?	❑No ❑Yes	12a. When? *If in the past 12 months, ask these questions:* 12b. Were shared or non-sterile instruments or needles used? ❑No ❑Yes
13a. Did she/he* **EVER** live with, or was she/he* cared for by, a person who has hepatitis?	❑No ❑Yes	13a(i). Describe what happened and when. *If in the past 12 months, ask these questions:* 13a(ii). What type of hepatitis did **<u>that person</u>** have? 13a(iii). 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
14. Did she/he* **EVER** come into contact with someone else's blood?	❑No ❑Yes	14a. Describe what happened and when: 14b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis? ❑No ❑Yes
15. Did she/he* **EVER** have an accidental needle-stick?	❑No ❑Yes	15a. Describe what happened and when: 15b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis? ❑No ❑Yes
16. Was she/he* **EVER** given or did she/he* use	❑No	16a. What was it?

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drugs, such as steroids, cocaine, heroin, amphetamines, or anything **NOT** prescribed by her/his* doctor?	❑Yes	16c. When was it last used? 16d. Were needles used? ❑No ❑Yes *If no,* 16d(i). How was it taken?
17. Did she/he* **EVER** have any kind of surgery?	❑No ❑Yes	17a. What kind? 17b. Where? 17c. When?
18. Did she/he* **EVER** travel or live outside of the United States or Canada?	❑No ❑Yes	18a. Where? 18b. When and for how long? 18c. Did she/he* **EVER** receive a blood transfusion or other medical treatment outside of the United States or Canada? ❑No ❑Yes *If yes,* 18c(i). What occurred (which one)? 18c(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 #10.*
19a. Did she/he* **EVER** have a transplant or medical procedure that involved being exposed to <u>live</u> cells,	❑No ❑Yes	19a(i). Explain:

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tissues or organs from an animal? **19b.** Did she/he* live with a person who had?	❑No ❑Yes	19b(i). Who was it?
20. Did she/he* **EVER** have a positive or reactive test for: **20b.** the HIV/AIDS virus?	❑No ❑Yes	20b(i). Explain:
20c. hepatitis?	❑No ❑Yes	20c(i). Explain:
20d. HTLV-I or HTLV-II?	❑No ❑Yes	20d(i). Explain:
21. Did she/he* **EVER** have liver disease or hepatitis?	❑No ❑Yes	21a. What kind? 21b. When?

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23. Did she/he* **EVER** have cancer?	❑No ❑Yes	23a. What type? 23b. When was it diagnosed? 23c. Describe when and where surgery, radiation, or chemotherapy occurred: 23d. Was the cancer considered cured? ❑No ❑Yes *If yes,* 23d(i). When?
24. Did she/he* **EVER** have any eye problems, procedures, or surgery?	❑No ❑Yes	*If yes to eye problems:* 24a. What kind of eye problems? *If yes to eye surgery or procedures:* 24b. What kind of surgery or procedure was performed and why? 24c. Which eye(s)? ❑ left ❑ right ❑ unknown 24d. What is the name and/or phone number of her/his* eye doctor or eye clinic?
25. Did she/he* or **any** of her/his* relatives have Creutzfeldt-Jakob disease, which is also called CJD or variant CJD?	❑No ❑Yes	25a. Who did? *If a relative,* 25a(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,* 25a(ii). Which blood relative? 25b. Is there a physician, relative, or other person who can provide more information*?* *(document discussion)*

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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. For the next part, a sexual act refers to any method of sexual contact including vaginal, anal, and oral.

26. Did she/he* **EVER** have an infection such as syphilis, gonorrhea, chlamydia, or genital ulcers, herpes, or genital warts?	❑No ❑Yes	26a. What was it? 26b. How was it treated? 26c. How long ago?
27. Do you have any reason to believe that she/he* was **EVER** involved in a sexual act, or was sexually assaulted or abused?	❑No ❑Yes	27a. How long ago? 27b. Was any sexual act in exchange for money or drugs? ❑No ❑Yes **The following questions are about any person with whom sexual contact occurred. I will read each question and you should answer to the best of your knowledge with a "Yes" or "No."** 27c. Was the person male or female? ❑Female ❑Male *If male,* 27c(i). Was this person known to have sex with another male? ❑No ❑Yes *If yes,* 27c(ii). When were they known to have sex with another man? 27d. Were they a person who has had sex in exchange for money or drugs? ❑No ❑Yes *If yes,* 27d(i). When were they known to have had sex in exchange for money or drugs?

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		27e. Were they a person who used a needle to inject drugs that were not prescribed by their own doctor? ❑No ❑Yes *If yes,* 27e(i). When were they known to have used a needle to inject drugs not prescribed by their own doctor? 27g. Were they a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV? ❑No ❑Yes *If yes,* 27g(i) Which virus? 27g(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 27h. Were they a person who received a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal? ❑No ❑Yes *Note to interviewer: Question 27i., the HIV-1 Group O Risk Question, must be asked if the test kit being used for HIV-1* ***Ab*** *testing is not labeled to include HIV-1 Group O.* *Check here if question 27i. was skipped.* ❑ 27i. Were they a person who was born in or lived in any country in Africa? ❑No ❑Yes *If yes,* 27i(i). What country were they from?
28. *If donor's age is 6 to 12 years (inclusive), ask:* Was she/he* **EVER** in lockup, jail, prison, or any juvenile correctional facility?	❑N/A ❑No ❑Yes	*(donor's age is <6 years)* 28a. When? 28b. How long? 28c. Where?

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FINAL QUESTIONS		
33. Are there other medical conditions you are aware of that we have not discussed?	❑No ❑Yes	33a. Describe:
34. Do you now have any concerns that her/his* donation should not proceed?	❑No ❑Yes	34a. Can you share your concerns?
35. Regarding these questions, are there other people, including healthcare professionals, who may provide additional information?	❑No ❑Yes	35a. Name(s) and contact information:
36. Do you have any questions about these questions?	❑No ❑Yes	36a. Document:
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?
ADDITIONAL NOTES		

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