



Eye-Only Donor Risk Assessment Interview Birth Mother

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Child Donor's Name:	_____	_____	_____
	First	Middle	Last
Birth Mother's Name:	_____	_____	_____
	First	Middle	Last
Person Interviewed:	_____		_____
	Name		Relationship to Birth Mother
Contact Information:	_____(____)	_____	_____
	Phone	Address	City State Zip
The interview was conducted:	by telephone <input type="checkbox"/>	in person <input type="checkbox"/>	
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."

Check if the DRAI for the Birth Mother is the only DRAI that will be completed. This circumstance occurs only when the child donor has not left the hospital since birth. See Question #27.

A1. Have you/she EVER been quarantined, investigated, diagnosed, or treated for a potentially communicable illness (e.g. Influenza A, SARS, or Ebola)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	(i). Please explain and include date(s): (ii) Treatment?
A2. Have you/she EVER had 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)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Please explain:
2a. Did you (she*) have a family physician or a specialist?	<input type="checkbox"/> No <input type="checkbox"/> Yes	2a(i). When was your/her* last visit? 2a(ii). Why? 2a(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):

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<p>2b. Did you (she*) use a medical facility such as a clinic or urgent care center?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2b(i). When was your (her)* last visit? 2b(ii). Why?</p> <p>2b(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):</p>
<p>3. Did you/she* recently have any symptoms such as:</p> <p>3a. a fever?</p> <p>3b. cough?</p> <p>3c. diarrhea?</p> <p>3d. swollen lymph nodes or glands in the neck, armpits or groin?</p> <p>3e. weight loss?</p> <p>3f. a rash?</p> <p>3g. sores in the mouth or on the skin?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><i>If any answer in question 3. is "yes," ask "when" this occurred <u>and</u> "describe symptoms and reasons," if known.</i></p> <p>3a(i). When? 3a(ii). Describe the fever and reasons.</p> <p>3b(i). When? 3b(ii). Describe the cough and reasons.</p> <p>3c(i). When? 3c(ii). Describe diarrhea and reasons.</p> <p>3d(i). When? 3d(ii). Describe swollen lymph nodes or glands and reason.</p> <p>3e(i). When? 3e(ii). Describe how much weight loss and reason(s).</p> <p>3f(i). When? 3f(ii). Describe the rash and reasons.</p> <p>g(i). When? 3g(ii). Describe the sores and reasons.</p>

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<p>3h. night sweats?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>3h(i). When? 3h(ii). Describe night sweats and reasons.</p>
<p>4. In the past 12 months were you (was she*) in lockup, jail, prison, or any juvenile correctional facility?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>4a. How long? 4b. Where?</p>
<p>5. In the past 12 months were you (was she*) bitten or scratched by any pet, stray, farm, or wild animal?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>5a. What kind of animal? 5b. When? 5c. Did you (she*) receive any medical treatment? <input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i> 5c(i). By whom? 5d. Was the animal suspected of having rabies? <input type="checkbox"/>No <input type="checkbox"/>Yes 5e. Was the animal quarantined or tested? <input type="checkbox"/>No <input type="checkbox"/>Yes 5e(i). Which one? <i>If yes to tested,</i> 5e(ii). What was the result?</p>

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<p>6. In the past 12 months were you (was she*) told by a healthcare professional that you/she* had a West Nile virus infection?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>6a. When were you (was she*) diagnosed?</p> <p style="text-align: center;"><i>If this occurred within the past 4 months ask:</i> 6a(i). What was the name of the doctor/clinic?</p>
<p>7. In the past 12 months did you/she* have any shots or immunizations, such as for the flu, MMR, yellow fever, hepatitis B, etc.?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>7a. When?</p> <p>7b. What kind was it?</p> <p style="text-align: center;"><i>If smallpox/vaccinia is named, ask these questions:</i></p> <p>7b(i). Did you/she* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 7b(i)a. When did these symptoms resolve? <p>7b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>?</p> <p>7b(ii)a. When?</p>
<p>This is a reminder these are standard questions we ask in every interview.</p> <p>Answer to the best of your knowledge with a "Yes" or "No."</p>		
<p>8. In the past 12 months did you/she* get a tattoo, touch up of an old tattoo, or permanent makeup?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>8a. Were shared or non-sterile instruments, needles or ink used?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes

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<p>9. In the past 12 months did you/she* have acupuncture, ear or body piercing?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>9a. Were shared or non-sterile instruments or needles used?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes
<p>10. In the past 12 months did you/she* live with a person who has hepatitis?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>10a. What type of hepatitis did that person have?</p> <p>10b. 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?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes
<p>11. In the past 12 months did you/she* come into contact with someone else's blood?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>11a. Describe what happened and when:</p> <p>11b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes
<p>12. In the past 12 months did you/she* have an accidental needle-stick?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>12a. Describe what happened and when:</p> <p>12b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes
<p>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 questions about sexual history.</p>		
<p>13. In the past 12 months did you/she* have a sexually transmitted infection such as syphilis, gonorrhea, chlamydia, or genital ulcers, herpes, or genital warts?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>13a. What was it?</p>

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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."

<p>14. The following questions relate to the past 5 years:</p> <p>14a. Did you/she* have sex in exchange for money or drugs?</p> <p>14b. Did you/she* have sex with a person who has had sex in exchange for money or drugs?</p> <p>14c. Did you/she* have sex with a male who had sex with another male?</p> <p>14d. Did you/she* have sex with a person who used a needle to inject drugs that were not prescribed by their own doctor?</p> <p>14f. Did you/she* have sex with a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>14a(i). When?</p> <p>14b(i). When?</p> <p>14c(i). When?</p> <p>14d(i). When?</p> <p>14f(i). Which virus and when?</p> <p>14f(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?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>
<p>16. Did you/she* EVER use or take drugs, such as steroids, cocaine, heroin, amphetamines, or anything NOT prescribed by your/her* doctor?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>16a. What was it?</p> <p>16c. When was it last used?</p>

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		<p>16d. Were needles used?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><i>If no,</i></p> <p>16d(i). How was it taken?</p>
<p>17a. Did you/she* EVER have a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?</p> <p>17b. Did you/she* live with, or have sex with, a person who had?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>17a(i). Explain:</p> <p>17b(i). Explain:</p>
<p>19. Did you/she* EVER travel or live outside of the United States or Canada?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>19a. Where?</p> <p>19b. When and for how long?</p> <p><i>If international travel or residency is extensive, be aware of query regarding vaccinations or other shots (within the past 12 months) at question #7.</i></p>

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<p>20. Did you/she* EVER have a positive or reactive test for:</p> <p style="margin-left: 20px;">20a. the HIV/AIDS virus?</p> <p style="margin-left: 20px;">20b. hepatitis?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>20a(i). Explain:</p> <p>20b(i). Explain:</p>
<p>21. Did you/she* EVER have liver disease or hepatitis?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>21a. What kind?</p> <p>21b. When?</p>
<i>Final Questions</i>		
<p>24. Do you (Does she)* have other medical conditions that we have not discussed?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>24a. Describe:</p>
<p>25. Regarding these questions about you/her*, are there other people, including healthcare professionals, who may provide additional information?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>25a. Name(s) and contact information:</p>
<p>26. Do you have any questions about these questions?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>26a. Document:</p>
<p><i>Note to interviewer: Question 27 must be asked if the child donor has not left the hospital since birth and a "DRAI - Child donor ≤10 years old" will not be completed. Check here if this question is skipped <input type="checkbox"/>.</i></p>		

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<p>27. Did any of your child's relatives have Creutzfeldt-Jakob disease, which is also called CJD?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>27a. Who did?</p> <p style="margin-left: 40px;"><i>27a(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)</i></p> <p style="margin-left: 40px;"><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="margin-left: 40px;"><i>If yes,</i> 27a(i)a. Which blood relative?</p>
<p><i>Note to interviewer: Questions 28a & 28b, the HIV-1 Group O Risk Questions, 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 these questions are skipped <input type="checkbox"/>.</i></p>		
<p>28a. Did you/she* EVER have sex with a person who was born in or lived in a country in Africa?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>28a(i). When was the person born, or when did the person live, in Africa?</p> <p style="margin-left: 40px;"><i>If since 1977:</i> 28a(ii). What country in Africa were they from?</p>
<p>28b. Did you/she* EVER travel to a country in Africa?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>28b(i). When?</p> <p style="margin-left: 40px;"><i>If since 1977:</i> 28b(i)a. What country in Africa?</p> <p style="margin-left: 40px;">28b(i)b. Did you/she* receive a blood transfusion or other medical treatment while in Africa?</p> <p style="margin-left: 40px;"><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="margin-left: 40px;"><i>If yes, explain:</i></p>

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Additional Notes

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