Trillium Gift of Life Network

TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

Trillium Gift of Life Network
483 Bay Street South Tower,
4th Floor Toronto
Ontario M5G2C9

CSF-9-262

Donor Name: _____ **Donor Date of Birth:** __/__/____
First Middle Last DD/MM/YYYY

Place of Interview: ❑ Phone ❑ Hospital ❑ Other _____ **Date-Time Interviewed:** __/__/____ - __:__ EDT
DD/MM/YYYY hh:mm

Person Conducting Interview and Completing Form:

_____ _____ __/__/____ - __:__ EDT
Name (First and Last) Signature DD/MM/YYYY hh:mm

Person Interviewed: _____ _____
Name (First and Last) Relationship

Contact Information: _____ Canada
Address City Province Postal Code Country

(____)_____ Phone Type: ❑ Home ❑ Cell ❑ Work
Phone

Complete this section if an additional person was interviewed ❑ N/A

Person Interviewed: _____ _____
Name (First and Last) Relationship

Contact Information: _____ Canada
Address City Province Postal Code Country

(____)_____ Phone Type: ❑ Home ❑ Cell ❑ Work
Phone

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."

Reminders:
The DRAI Birth Mother must also be completed in the following scenarios:
a) ≤10 year old donors who have been breastfed within the last 12 months
b) Donors who are ≤18 months old
c) ONLY the DRAI Birth Mother is needed for pediatric donors who never left the hospital since birth

SECTION A: Person Interviewed

A1. How long have you known her/him*?		
A2. Do you know her/him well enough to be able to answer questions about her/his medical history or social and relationship lifestyle?	❑No ❑Yes	*If no, please provide the following information of the best person(s) to contact:* A2a. Name: A2b. Relationship: A2c. Phone Number:

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

SECTION B: Infection & Communicable Illness		
B1. In the past **12 months**, was she/he* investigated, diagnosed or treated for any type of infection?	❑No ❑Yes	B1a. What type of infection? B1b. Date and duration? B1c. Treatment?
B2. Was he/she* EVER quarantined, investigated, diagnosed, or treated for an emerging infectious disease (e.g. Tuberculosis, Zika, MERS, Ebola, Monkeypox or COVID-19)?	❑No ❑Yes	B2a. Please explain and include date(s): B2b. Treatment?
B3. Did he/she* EVER have 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, Ebola, Monkeypox or COVID-19)?	❑No ❑Yes	B3a. Please explain:
B4. Did she/he* **EVER** use or take human derived pituitary growth hormone?	❑No ❑Yes	B4a. When was it used? B4b. What kind was it? B4c. In which country or countries did the treatment take place?
B5. Did she/he* **EVER** receive an organ or tissue transplant, such as a kidney, dura mater, cornea, bone, skin or heart valve?	❑No ❑Yes	B5a. Type of tissue or organ transplant? B5b. Date? B5c. Any complications?
SECTION C: Donor Risk Assessment Interview Child Donor ≤ 10 years old		
1. Within the past **12 months**, was she/he* breastfed or was she/he* fed breast milk from another person?	❑No ❑Yes	1a. Who provided the breast milk? *If this is the birth mother, complete the TGLN DRAI Birth Mother in addition to this form.*

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

2. Where was she/he* born?		
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.*
3a. a bleeding disorder?	❑No ❑Yes	3a(i). When? 3a(ii). What was the reason? 3a(iii). Did she/he* receive medication for the bleeding problem? ❑No ❑Yes 3a(iii)a. *If yes,* What was its name? 3a(iv). Was the medication human derived? ❑No ❑Yes
3b. lung disease such as asthma, cystic fibrosis or tuberculosis?	❑No ❑Yes	3b(i). Explain:
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 3d(ii)a. *If yes,* How?
3e. high blood pressure?	❑No ❑Yes	3e(i). Explain: 3e(ii). For how many years?
3f. heart problems or heart disease?	❑No ❑Yes	3f(i). Explain:

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

		3f(ii). How was it treated?
3g. an autoimmune disease?	❑No ❑Yes	3g(i). Explain:
3h. health problems related to toxic substances?	❑No ❑Yes	3h(i). Explain:
3i. kidney disease, frequent kidney infections, or was she/he* treated with dialysis?	❑No ❑Yes	3i(i). Explain and include when: 3i(ii). If treated with dialysis, was it peritoneal dialysis or hemodialysis? ❑Peritoneal Dialysis ❑Hemodialysis
3j. a birth defect or syndrome, or an infection identified at birth?	❑No ❑Yes	3j(i). Explain:
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.):*

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

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? *Was a steroid, such as prednisone named?* ❑No ❑Yes *If a steroid, such as prednisone was named, ask:* 5a(ii). How long? 5a(ii). What was the dose?
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 reason(s):
6b. cough?	❑No ❑Yes	6b(i). When? 6b(ii). Describe the cough and reason(s):
6c. diarrhea?	❑No ❑Yes	6c(i). When? 6c(ii). Describe the diarrhea and reason(s):
6d. swollen lymph nodes or glands in the neck, armpits or groin?	❑No ❑Yes	6d(i). When? 6d(ii). Describe the swollen lymph nodes or glands and reason(s):

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TGLN Donor Risk Assessment Interview
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6e. weight loss?	❑No	6e(i). When?
	❑Yes	6e(ii). Describe how much weight loss and reason(s):
6f. a rash?	❑No	6f(i). When?
	❑Yes	6f(ii). Describe the rash and reason(s):
6g. sores in the mouth or on the skin?	❑No	6g(i). When?
	❑Yes	6g(ii). Describe the sores and reason(s):
6h. night sweats?	❑No	6h(i). When?
	❑Yes	6h(ii). Describe night sweats and reason(s):
6i. severe headache?	❑No	6i(i). When?
	❑Yes	6i(ii). Describe the severe headache and reason(s):
6j. rapid decline in <u>mental</u> functions, such as behaving differently than normal?	❑No	6j(i). When?
	❑Yes	6j(ii). Describe rapid decline in mental functions and reason(s):
6k. rapid decline in <u>physical</u> functions, such as moving differently than normal?	❑No	6k(i). When?
	❑Yes	6k(ii). Describe decline in physical functions and reason(s):
7. Did she/he* have contact with anyone who had a smallpox vaccination?	❑No	7a. Was **that person** vaccinated within the past 2 months? ❑No ❑Yes
	❑Yes	7a(i). *If yes,*

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

		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 7a(i)a. *If yes,* Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? ❑No ❑Yes 7a(i)a(i). *If yes,* Explain:
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 8c(i). *If yes,* 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? ❑Quarantined ❑Tested *If yes to tested,* 8e(i)a. 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? *Did this occur within the past 4 months?* ❑No

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

		❑Yes 9a(i). *If this occurred within the past 4 months ask:* 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? *Was smallpox/vaccinia named?* ❑No ❑Yes *<u>If smallpox/vaccinia was named</u>, ask:* 10b(i). Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? ❑No ❑Yes 10b(i)a. *If yes,* When did these symptoms resolve? 10b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>? ❑Fell off ❑Picked off 10b(ii)a. When?
This is a reminder that these are standard questions we ask in every interview. **Please answer to the best of your knowledge with a "Yes" or "No."**		
11. In the past **12 months** did she/he* get a tattoo?	❑No ❑Yes	11a. Were shared or non-sterile instruments, needles or ink used? ❑No ❑Yes 11b. Was the procedure performed outside of the United States or Canada? ❑No ❑Yes 11b(i). *If yes,* Where?

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

12. In the past **12 months** did she/he* have acupuncture, ear or body piercing?	❑No ❑Yes	12a. Were shared or non-sterile instruments or needles used? ❑No ❑Yes 12b. Was the procedure performed outside of the United States or Canada? ❑No ❑Yes 12b(i). *If yes,* Where?
13a. In the past **12 months** did she/he* live with, or was she/he* cared for by, a person who has hepatitis?	❑No ❑Yes	13a(i). What type of hepatitis did **<u>that person</u>** have? 13a(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
13b. Did she/he* **EVER** live with, or was she/he* cared for by, a person who has tuberculosis?	❑No ❑Yes	13b(i). Describe what happened and when:
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 drugs, such as steroids, cocaine, heroin, amphetamines, or anything **NOT** prescribed by her/his* doctor?	❑No ❑Yes	16a. What was it? 16b. How often and how long was it used? 16c. When was it last used? 16d. Were needles used?

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

		❑No ❑Yes 16d(i). *If no,* 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, tissues or organs from an animal?	❑No ❑Yes	19a(i). Explain:
19b. Did she/he* **EVER** live with a person who had a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?	❑No ❑Yes	19b(i). Who was it?

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

20. Did she/he* **EVER** have a positive or reactive test for:		
20a. tuberculosis, such as a positive skin or blood test?	❑No ❑Yes	20a(i). Explain:
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:
20e. *T. cruzi* or told she/he* has Chagas' disease?	❑No ❑Yes	20e(i). Explain:
21. Did she/he* **EVER** have liver disease or hepatitis?	❑No ❑Yes	21a. What kind? 21b. When?
22. Did she/he* **EVER** have malaria?	❑No ❑Yes	22a. When? 22b. Where was she/he* treated?
23. Did she/he* **EVER** have cancer?	❑No ❑Yes	23a. What type? *Was skin cancer named?* ❑No ❑Yes 23a(i). *If skin cancer:* What kind? 23b. When was it diagnosed? 23c. Describe when and where surgery, radiation, or chemotherapy occurred: 23d. Was the cancer considered cured?

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

		❑No ❑Yes 23d(i). *If yes,* When?
24. Did she/he* **EVER** have any eye problems, procedures, or surgery?	❑No ❑Yes	24a. *If yes to eye problems:* What kind of eye problems? 24b. *If yes to eye surgery or procedures:* What kind of surgery or procedure was performed and why? 24c. Which eye(s)? ❑ left ❑ right ❑ both ❑ 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 any prion-related disease, such as Creutzfeldt-Jakob disease, which is also called CJD or variant CJD, or any form of mad cow disease?	❑No ❑Yes	25a. Who did? 25a(i). *If a relative,* 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 25a(ii). *If yes,* Which blood relative? 25b. Is there a physician, relative, or other person who can provide more information*? (document discussion)*
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?

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

		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. Please answer to the best of your knowledge with a "Yes" or "No."** 27c. Was the person male or female? ❑Female ❑Male 27c(i). *If male,* Was this person known to have sex with another male? ❑No ❑Yes 27c(i)a. *If yes,* 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 27d(i). *If yes,* When were they known to have had sex in exchange for money or drugs? 27e. Were they a person who used a needle to inject drugs that were not prescribed by their own doctor? ❑No ❑Yes 27e(i). *If yes,* When were they known to have used a needle to inject drugs not prescribed by their own doctor? 27f. Were they a person who has received medication for a bleeding disorder such as hemophilia? ❑No

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TGLN Donor Risk Assessment Interview
Child Donor ≤10 years old

		❑Yes 27f(i). *If yes,* What was it and when was it used? [ ] 27g. Were they a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV? ❑No ❑Yes 27g(i) *If yes,* 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
28. *If donor's age is 6 to 10 years (inclusive), ask:* Was she/he* **EVER** in a youth correctional facility, jail, lockup, or prison?	❑N/A ❑No ❑Yes	28a. When? [ ] 28b. How long? [ ] 28c. Where? [ ] 28d. Why? [ ]
29. Did she/he* EVER experience homelessness or live in a homeless shelter?	❑No ❑Yes	29a. When? [ ] 29b. How long? [ ]
Final Questions		
30. Are there other medical conditions you are aware of that we have not discussed?	❑No ❑Yes	29a. Describe: [ ]

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31. Do you now have any concerns that her/his* donation should not proceed?	❑No ❑Yes	30a. Can you share your concerns?
32. Regarding these questions, are there other people, including healthcare professionals, who may provide additional information?	❑No ❑Yes	31a. Name(s) and contact information:
33. Do you have any questions about these questions?	❑No ❑Yes	32a. Document:

SECTION D: Funeral Arrangements

D1. Have funeral or final resting place arrangements been made?	❑No ❑Yes	D1a. Which funeral home (or equivalent) did you make the arrangements with? D1b. Name(s) and contact information: D1c. May we contact the funeral home to notify them of the donation and recovery timelines if required?

Additional Notes

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