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

Trillium Gift of Life Network
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INSTRUCTIONS

- **Complete this Med-Soc questionnaire manually**
- **Make a note in each iTransplant Med-Soc Comments field to "see the attachment" for answers to questions**
- **Once complete, scan or save the form and upload it as an attachment to the donor chart**
- **Please name the file appropriately and categorize the attachment under the "Other" group**

Temporary Supplemental Med-Soc Questions (Ocular and Multi-tissue potential donors)

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

Name of Interviewee(s): _____

Relationship(s): _____

Healthcare Professional who conducted the interview and completed the questionnaire:

Name:_____

Title: _____

Date of Interview:_____Signature of Interviewer: _____

TGLN ID #: _____

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Travel Additional Questions			
70a	Did she/he **EVER** travel or live outside of the United States or Canada?	□ **No**	□ **Yes** □ **Unknown** If yes, where: When and for how long? Did she/he **EVER** receive a blood transfusion or other medical treatment outside of the United States or Canada? ❑No ❑Yes *If yes,* a(i). What occurred (which one)? a(ii). Describe where and when:

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70 b	Was she/he **EVER** a U.S. military member, a civilian military employee, or a dependent of either?	□ **No**	□ **Yes** □ **Unknown** Did she/he ever live or work on a U.S. military base outside the United States? ❑No ❑Yes *If yes,* b(i). In which country or countries? b(ii). When? *If this occurred between 1980 and 1996 in Europe:* b(ii)a. How long? *(estimate total time)*

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Infectious Disease Additional Questions			
81	Did she/he recently have any symptoms such as:		*If any answer is "yes,"* ask "when" *this occurred <u>and</u>* "describe symptoms and reasons," *if known.*
	a. a fever?	❑No	
		❑Yes	a(i). When? a(ii). Describe the fever and reasons.
	b. cough?	❑No	
		❑Yes	b(i). When? b(ii). Describe the cough and reasons.
	c. diarrhea?	❑No	
		❑Yes	c(i). When? c(ii). Describe diarrhea and reasons.
	d. swollen lymph nodes or glands in the neck, armpits or groin?	❑No	
		❑Yes	d(i). When? d(ii). Describe swollen lymph nodes or glands and reasons.
	e. weight loss?	❑No	
		❑Yes	e(i). When? e(ii). Describe how much weight loss and reason(s).
	f. a rash?	❑No	
		❑Yes	f(i). When? f(ii). Describe the rash and reasons.

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

82	Did she/he know anyone who had a smallpox vaccination?	❑No ❑Yes	a. Was **that person** vaccinated within the past two months? ❑No ❑Yes *If yes,* a(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,* a(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:
83	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	a. When? b. What kind was it? *<u>If smallpox/vaccinia is named</u>, ask these questions:* b(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,* b(i)a. When did these symptoms resolve? b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>? 12b(ii)a. When?

84	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	a. What was she/he told by a physician?
85	Did she/he **EVER** have liver disease or hepatitis?	❑No ❑Yes	a. What kind? b. When?