



DONOR NUMBER	NHI NUMBER (or affix patient label)	DATE OF BIRTH or affix patient label)
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Donor Name:..... Person(s) Interviewed regarding history: Name:..... Relationship:..... Name:..... Relationship:.....	GP / Clinic: Phone Number GP / Clinic: Phone Number:
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To proceed with organ and tissue donation, it is necessary for us to ask you some questions about (donor's name) medical and lifestyle history. All information will be treated in the strictest confidence.

Do you feel that you knew (donor's name) well enough to answer questions about their medical and lifestyle history? Yes / No
 If no, is there someone who might know?

Name: Name:
 Phone Number: Phone Number:
 Relationship: Relationship:

- All questions must be answered for organ donors, except those specific to eye or skin tissue if these are not being considered.
- Questions marked by an asterisk (*) are not required for tissue-only donors.
- NA must be circled for questions that are not required. Do not leave any answers blank.
- "Yes" answers require clarification and may not necessarily preclude donation.
- "Don't know" answers should be recorded as "No" and must be discussed with the donor coordinator.

Paediatric Donor Information:

For paediatric donors, consider mother's risk factors as well as the child's for donors of less than 18 months old, or older if the child has been breast-fed within the last 12 months, whichever is the greater time. If needed, write 'M' or 'C' before the answer to show that it refers to the mother, or the child, respectively.

ALL DONORS (questions marked by an asterisk (*) are not required for tissue-only donors)	
1. Do they have any allergies? If yes, what?	Yes / No
2. Have they ever had any serious illnesses, infections, surgery or been admitted to hospital?	Yes / No
Have they had any surgery of the brain or spinal cord?	Yes / No
Any significant family medical history?	Yes / No



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3. In the past 6 months have they: <ul style="list-style-type: none"> • visited a doctor or health clinic • had any recent health concerns • had any medical or surgical procedures e.g. endoscopy 		Yes / No
4. Have they had dental treatment, a cold sore, cold, cough, sore throat or any other infection in the last week?		Yes / No
5. Have they had, or any member of the household had any diarrhoea, vomiting, stomach pain or upset stomach in last 3 months?		Yes / No
6. Have they ever had cancer of any kind including melanoma, skin cancer or leukaemia? Any radiotherapy or chemotherapy?		Yes / No Yes / No
7. Did they take any medication, including vitamins, or herbal remedies on a regular basis? Have they ever taken steroids for more than a few weeks at a time? Have they had any treatment for acne or psoriasis in the past 3 years?		Yes / No Yes / No Yes / No
8. Have they ever had heart problems endocarditis, rheumatic fever, heart murmur, congenital heart conditions, previous cardiac surgery or chest pain? Is there any family history of heart disease?		Yes / No Yes / No
9. * Did they have a history of high blood pressure? If yes, for how long? • Treated with?		Yes / No / NA
10. * Have they ever had any lung problems including asthma? * Is there any family history of lung disease?		Yes / No / NA Yes / No / NA
11. Did they smoke tobacco or any other substances? • If yes, what did they smoke? • How much did they smoke? • How long did they smoke for? • Had they given up smoking? If so, when?		Yes / No
12. Did they ever have any liver diseases such as jaundice or hepatitis? In the last 12 months, have they been in close contact with anyone who was diagnosed with hepatitis?		Yes / No Yes / No



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13. * Did they drink alcohol? • If yes, what did they drink? • How much and how often?		Yes / No / NA
14. Did they ever have any kidney problems including dialysis treatment? Is there a family history of kidney problems?		Yes / No Yes / No
15. Did they have a history of diabetes? • If yes, how long have they been diabetic for? • If yes, were they treated with tablets or insulin injections?		Yes / No
16. Have they ever had any connective tissue disease (e.g. Marfan's, Ehlers-Danlos Syndrome)?		Yes / No
17. Were they vaccinated or immunised in the last 6 months for any reason? If yes, what immunisation or vaccination, when, where and by whom?		Yes / No
18. Have they ever been treated for exposure to a toxic substance, e.g. lead, pesticides, radiation, mercury?		Yes / No
19. Have they ever donated blood in New Zealand? Have they ever been refused from donating blood?		Yes / No Yes / No
TRAVEL AND OTHER INFECTIOUS RISK		
20. Have they ever lived or travelled outside of New Zealand or Australia? If yes, when, where and for how long?		Yes / No
21. Have they ever had Malaria, Typhus, Ross River Fever, Q Fever, Leptospirosis, Toxoplasmosis, West Nile Virus, Chagas disease, Syphilis, Gonorrhoea or Tuberculosis?		Yes / No
"WINDOW PERIOD" VIRAL INFECTION		
22. In the last 3 months, have they had a tattoo, ear or other body piercing, acupuncture or cosmetic treatments that involve piercing the skin (e.g. micro blading, derma rolling)?		Yes / No
23. Have they been injured with a used needle?		Yes / No
24. Have they had a blood or body fluid splash to eyes, mouth, nose or broken skin?		Yes / No
25. In the last 6 months have they had any history of unexplained infection, fever, weight loss, swollen glands, persistent cough or night sweats?		Yes / No



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TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES

26. Did they receive any injection of human pituitary extracts such as growth hormone or gonadotrophin (growth or Fertility treatment) before 1985?	Yes / No
27. Do you know if they or anyone in the family has or had <ul style="list-style-type: none"> • Creutzfeldt -Jakob Disease (CJD)? • Gertsman – Straussler – Scheinker Syndrome (GSS)? • Fatal Familial Insomnia (FFI)? 	Yes / No
28. Did they have any type of diagnosed brain disease such as dementia, Alzheimer’s, Multiple Sclerosis, Parkinson’s disease or Motor Neurone disease?	Yes / No
29. Have they had recent memory loss, confusion, unsteady movements, uncoordinated speech or any unexplained neurological condition?	Yes / No
30. Did they ever receive a blood transfusion or have treatment with plasma clotting factors here or overseas? Eg. United Kingdom, Republic of Ireland, France or South/Central America	Yes / No
31. Did they ever receive a human organ or tissue transplant or an animal tissue transplant or graft such as bone, skin, cornea, dura mater, heart valve, vein, bone marrow, or stem cell?	Yes / No
32. Did they have any history of an autoimmune disease such as Systemic Lupus Erythematosus, Rheumatoid Arthritis, Sarcoidosis, Polyarteritis nodosa, or Scleroderma?	Yes / No

EYE DONATION (circle NA if eye tissue donation is not considered)

33. Did they have any history of eye diseases, infections, cataracts, glaucoma, retinopathy, corneal diseases, eye tumours or operations involving the eyes, including laser vision correction (LASIK)? If yes, when, where, treating doctor?	Yes / No / NA
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SKIN DONATION (circle NA if skin donation is not considered)

34. Did they have a history of skin infections such as leprosy, eczema, dermatitis or inflammatory skin conditions or abrasions?	Yes / No / NA
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Some infections (e.g. HIV and Hepatitis) can be transmitted through organ or tissue transplants. To help assess this risk, we use blood tests along with a review of the donor's medical and social history. I will now list some situations where there might be an increased risk, and I will ask if any of these could apply.

(For children under 18 months or children breast-fed within the last 12 months, these questions apply to the mother of the child.)

Anyone who:

- has (or had) AIDS or a positive test for HIV or have ever taken any medication to treat an HIV infection.
- has ever had a sexual partner who has (or had) AIDS or a positive test for HIV or have ever taken any medication to treat an HIV infection.
- carries the Hepatitis B or C virus or has had syphilis
- has injected themselves, even once, with drugs not prescribed by a doctor in the last 5 years
- has haemophilia or related clotting disorder and has ever received treatment with plasma derived clotting factor concentrates

Anyone who in the last 3 months:

- has used any medication to prevent an HIV infection (i.e. pre or post exposure prophylaxis)
- has contracted gonorrhoea or any other sexually transmitted disease
- has had a new sexual partner with whom they had anal sex
- has had more than one sexual partner and has engaged in anal sex
- has engaged in sex work (prostitution) or accepted payment in exchange for sex
- has been an inmate of a prison or correctional institution

Anyone who in the last 3 months has had sex with any of the following groups:

- anyone who lives in or comes from a country considered high risk for HIV infection (see map)
- anyone whom you know carries the Hepatitis B or C virus
- anyone who has ever injected themselves with drugs not prescribed by a doctor
- anyone with haemophilia or a related blood clotting disorder who has ever received plasma-derived clotting factor concentrates
- a sex worker (prostitute)

To the best of your knowledge, is it possible that any of these apply to (donor's name)?
(If yes provide details)

Yes / No

Is there anything else you can think of that may be significant in relation to their health or lifestyle?

Yes / No

Do you declare that the information provided is correct to the best of your knowledge?

Yes / No

Source/s of other information (specify – hospital medical records, GP, or other health records)

.....
.....

I have taken the above steps to ensure that the history obtained regarding the potential donor is current and accurate. I have interviewed the above person/s regarding history and have informed them, that in order to determine suitability for transplantation, access to any medical records may be required and that all information will be handled in the strictest confidence in accordance with the Health Information Privacy Code 2020

Interview conducted by: (Print Name)

Signature: Designation:

Date: DD / MM / YYYY Time: (use 24 hour clock)

Privacy Act

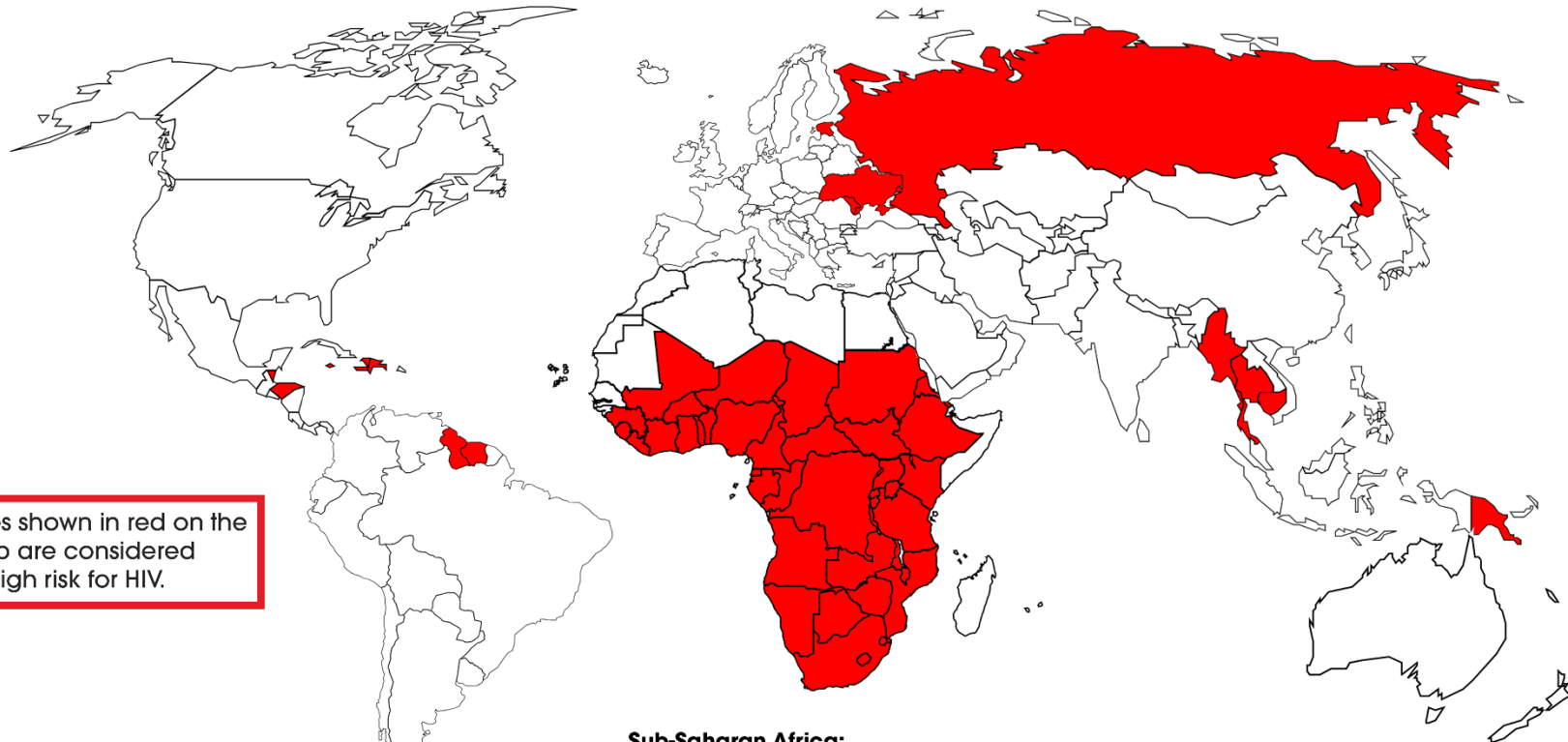
The information collected on this form will be used to assess the potential donor's eligibility to donate and held in accordance with the Privacy Act 2020 and the Health Information Privacy Code 2020 by one or more of the following services: Organ Donation New Zealand, New Zealand Eye Bank, and New Zealand Blood Service.

For Tissue Bank use only

Questionnaire: accepted / rejected _____ Signed: _____ Date: _____



Countries considered to be high risk for HIV infection are shown in red and listed below (taken from 111D082 v05).



Countries shown in red on the map are considered high risk for HIV.

Americas:

- Bahamas
- Barbados
- Belize
- Dominican Republic
- Guyana
- Haiti
- Honduras
- Jamaica
- Suriname
- Trinidad & Tobago

Asia Pacific:

- Cambodia
- Myanmar (formally Burma)
- Papua New Guinea
- Thailand

Europe:

- Estonia
- Moldova
- Russian Federation
- Ukraine

Sub-Saharan Africa:

- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cameroon
- Central African Republic
- Chad
- Congo
- Cote d'Ivoire
- Democratic Republic of Congo
- Djibouti
- Equatorial Guinea
- Eritrea
- Ethiopia
- Eswatini
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Malawi
- Mali
- Mozambique
- Namibia
- Niger
- Nigeria
- Rwanda
- Sierra Leone
- South Africa
- South Sudan
- Sudan
- Tanzania, United Republic
- Togo
- Uganda
- Zambia
- Zimbabwe