# MEDICAL / SOCIAL QUESTIONNAIRE ORGAN AND TISSUE DONORS

| DONOR NUMBER | NHI NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

Donor Name:

Person(s) Interviewed regarding history:

Name: .....

Relationship: .....

Name: .....

Relationship: .....

GP / Clinic: .....

Phone Number .....

GP / Clinic: .....

Phone Number: .....

**In order 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 his/her medical and lifestyle history? Yes / No

Is there someone who might know?

Name: ..... Name: .....

Phone number: ..... Phone number: .....

Relationship: ..... Relationship: .....

**All questions must be answered except tissue specific questions for which consent has not been obtained.**
**"Yes" answers may not necessarily exclude a donor from donating.**
**"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 up to 12 months beyond breast feeding, 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

| | |
|---|---|
| 1. Does (he/she) have any allergies? If yes, what? | Yes / No |
| 2. Has (he/she) ever had any serious illnesses, infections, surgery or been admitted to hospital? | Yes / No |
| Has (he/she) had any surgery of the brain or spinal cord? | Yes / No |
| Any significant family medical history? | Yes / No |
| 3. In the past 6 months has (he/she):<br>- visited a doctor or health clinic<br>- had any recent health concerns<br>- had any medical procedures e.g. endoscopy | Yes / No |
| 4. Has (he/she) had dental treatment, a cold sore, cold, cough, sore throat or any other infection in the last week? | Yes / No |

# MEDICAL / SOCIAL QUESTIONNAIRE ORGAN AND TISSUE DONORS

| DONOR NUMBER | NHI NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| | |
|---|---|
| 5. Has (he/she) had, or any member of the household had any diarrhoea, vomiting, stomach pain or upset stomach in last 3 months? | Yes / No |
| 6. Has (he/she) ever had cancer of any kind including melanoma, skin cancer or leukaemia?<br><br>Any radiotherapy or chemotherapy? | Yes / No<br><br>Yes / No |
| 7. Did (he/she) take any medication, including vitamins, steroids, or herbal remedies on a regular basis?<br><br>Has (he/she) had any treatment for acne or psoriasis in the past 3 years? | Yes / No<br><br>Yes / No |
| 8. Has (he/she) ever had heart problems, rheumatic fever, heart murmur, congenital heart conditions or chest pain?<br>Is there any family history of heart disease? | Yes / No |
| 9. Did (he/she) have a history of high blood pressure?<br>If yes, for how long?<br>Treated with? | Yes / No |
| 10. Has (he/she) ever had any lung problems including asthma or tuberculosis?<br>Is there any family history of lung disease? | Yes / No |
| 11. Did (he/she) smoke tobacco or any other substances?<br>If yes, what did (he/she) smoke?<br>How much did (he/she) smoke?<br>How long did (he/she) smoke for?<br>Had (he/she) given up smoking? If so, when? | Yes / No |
| 12. Did (he/she) ever have any liver diseases such as jaundice or hepatitis?<br>Has (he/she) had close contact, in the last 12 months, with anyone who was diagnosed with hepatitis? | Yes / No |
| 13. Did (he/she) drink alcohol?<br>What did he/she drink?<br>How much and how often? | Yes / No |
| 14. Did (he/she) ever have any kidney problems including dialysis treatment?<br>Is there a family history of kidney problems? | Yes / No |

# MEDICAL / SOCIAL QUESTIONNAIRE ORGAN AND TISSUE DONORS

| DONOR NUMBER | NHI NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| | |
|---|---|
| 15. Did (he/she) have a history of diabetes?<br>If yes, how long has he/she been diabetic for?<br><br>Was he/she treated with tablets or insulin injections? | Yes / No<br><br>Yes / No |
| 16. Has (he/she) ever had any connective tissue disease (e.g. Marfan's, Ehlers-Danlos Syndrome)? | Yes / No |
| 17. Was (he/she) vaccinated or immunised in the last 12 months for any reason?<br>If yes, what immunisation or vaccination, when, where and by whom? | Yes / No |
| 18. Has (he/she) ever been treated for exposure to a toxic substance, e.g. lead, pesticides? | Yes / No |
| 19. Has (he/she) ever donated blood in New Zealand?<br><br>Or been refused from donating blood? | Yes / No<br><br>Yes / No |
| **TRAVEL RISK** | |
| 20. Has (he/she) ever lived or travelled outside of New Zealand or Australia?<br><br>If yes, when, where and for how long? | Yes / No |
| 21. Has (he/she) ever had Malaria, Typhus, Ross River Fever, Q Fever, Leptospirosis, Toxoplasmosis, West Nile Virus or Chagas disease? | Yes / No |
| **"WINDOW PERIOD" VIRAL INFECTION** | |
| 22. In the last 6 months, has (he/she) had a tattoo, ear or other body piercing, acupuncture or cosmetic treatments that involve piercing the skin? | Yes / No |
| 23. Has (he/she) been injured with a used needle? | Yes / No |
| 24. Has he/she had a blood or body fluid splash to eyes, mouth, nose or broken skin? | Yes / No |
| 25. In the last 6 months has (he/she) had any history of unexplained infection, fever, weight loss, swollen glands, persistent cough or night sweats? | Yes / No |

# MEDICAL / SOCIAL QUESTIONNAIRE ORGAN AND TISSUE DONORS

| DONOR NUMBER | NHI NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| | |
|---|---|
| **TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES** | |
| 26. Did (he/she) 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 (he/she) or anyone in the family has or had<br>- Creutzfeldt -Jacob Disease (CJD)?<br>- Gertsmann – Straussler – Scheinker Syndrome (GSS)?<br>- Fatal Familial Insomnia (FFI)? | Yes / No |
| 28. Did (he/she) have any type of diagnosed brain disease such as dementia, Alzheimer's, Multiple Sclerosis, Parkinson's disease or Motor Neurone disease? | Yes / No |
| 29. Has (he/she) had recent memory loss, confusion, unsteady movements, uncoordinated speech or any unexplained neurological condition? | Yes / No |
| 30. Did (he/she) ever receive a blood transfusion or have treatment with plasma clotting factors here or overseas? | Yes / No |
| 31. Did (he/she) ever receive a human organ or tissue transplant or an animal tissue transplant or graft such as bone, skin, cornea, dura mater, heart valve or vein? | Yes / No |
| 32. Did (he/she) have any history of an autoimmune disease such as Systemic Lupus Erythematosus, Rheumatoid Arthritis, Sarcoidosis, Polyarteritis nodosa or Scleroderma? | Yes / No |
| **EYE DONATON** | |
| 33. Did (he/she) have any history of eye diseases, infections, cataracts, glaucoma, retinopathy, corneal diseases, eye tumours or operations involving the eyes, including laser vision correction (LASIK)?<br>If yes, when, where, treating doctor? | Yes / No |
| **SKIN DONATION** | |
| 34. Did (he/she) have a history of skin infections such as leprosy, eczema, dermatitis or inflammatory skin conditions or abrasions? | Yes / No |

# MEDICAL / SOCIAL QUESTIONNAIRE ORGAN AND TISSUE DONORS

| DONOR NUMBER | NHI NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

There are a number of infections that can be transmitted through transplants. Therefore we do not take donations from people who are at risk of contracting HIV or hepatitis. Your relative's blood will be tested but in rare cases, these tests may be negative even though infection is present. I will now read out a list of groups of people from whom we cannot accept donations and I will ask you to answer a question at the end of the list.
(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
- ever injected him/herself, even once, with drugs not prescribed by a doctor
- has haemophilia or related clotting disorder and has received treatment with plasma derived clotting factor concentrates at any time

Anyone who in the last 12 months:

- has used any medication to prevent an HIV infection (i.e. pre or post exposure prophylaxis)
- (men only) has had oral or anal sex with or without a condom with another man
- has engaged in sex work (prostitution) or accepted payment in exchange for sex
- has left a country in which they lived and which is considered to be high risk of HIV infection (see map)
- has been an inmate of a prison or correctional institution

Anyone who in the last 12 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 received plasma-derived clotting factor concentrates at any time
- a sex worker (prostitute)
- (women only) a man who has had oral or anal sex with another man

| | |
|---|---|
| **To the best of your knowledge, is it possible that any of these apply to *(donor's name)?*** | Yes / No |

**Thank you for participating in this interview. There are some people in the community who must not donate tissue or organs for transplantation due to the potential for transmitting infections to the people who receive the tissue or organs.**

| | |
|---|---|
| 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) .....

Designation: .....

Signature: ..... Phone number: .....

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.*

## MEDICAL / SOCIAL QUESTIONNAIRE ORGAN AND TISSUE DONORS

**Countries considered to be at high risk for HIV infection are shown in red and listed in the boxes (taken from 111D082 v04).**