



**TISSUE DONOR QUESTIONNAIRE – MEDICAL & SOCIAL HISTORY**

<b>Donor name:</b>		<b>DOB:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>NHI No:</b>
<b>Person interviewed</b>		<b>Relationship to potential donor</b>	<b>ODNZ Donor No:</b>
<b>Date &amp; Time of interview:</b>		<b>Interviewers name</b>	

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.

Do you feel that you knew (*donor’s name*) well enough to answer questions regarding their medical and social history? Yes  No

If not, can you suggest who else should be contacted:

*For Q1-21, 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.*

**To the best of your knowledge, has (*donor’s name*):**

1. Lived or travelled outside of New Zealand or Australia?	Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, when, where and for how long?)
2. Received a blood transfusion in the United Kingdom, Republic of Ireland or France from 1980 onwards?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Ever spent time in or had a blood transfusion in rural South/Central America?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Had any recent health concerns?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Had dental treatment, a cold sore, cold, cough, sore throat or any other infection in the last week?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Any significant family medical history?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Visited a doctor or health clinic in the last 6 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Been a New Zealand blood donor and/or been refused from donating blood?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Been taking any medication at all in the last two weeks (other than the contraceptive pill)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Had, or any of his/her household had any diarrhoea, vomiting, stomach pain or upset stomach in the last 12 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>



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11. In the last 6 months had any of the following:		
• vaccinations?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• needle stick injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• surgical operation	Yes <input type="checkbox"/> No <input type="checkbox"/>	
12. In the last 3 months had any of the following:		
• acupuncture, body/ear piercing, tattooing, invasive cosmetic procedures (i.e. micro blading, derma rolling)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• any medical procedure e.g. endoscopy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• blood transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	
13. In the last 12 months had any of the following:		
• hepatitis or jaundice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. In the last 3 years had treatment for acne or psoriasis?		
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
15. Ever had any of the following:		
• cancer, radiotherapy or chemotherapy, (including skin cancer or melanoma)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• kidney inflammation or infection or chronic haemodialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• an auto-immune disease (e.g. rheumatoid arthritis, SLE)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• an infectious disease, including malaria, Chagas, tuberculosis (TB), syphilis, gonorrhoea?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• exposure to chemicals such as mercury, lead or pesticides or radiation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• steroid treatment for more than a few weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
• a connective tissue disease (e.g. Marfan's, Ehlers-Danlos syndrome)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
16. Suffered from an unexplained neurological condition or had surgery of the brain or spinal cord?		
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
17. Received any injection of human pituitary extracts such as growth hormone or gonadotrophin (growth or fertility treatment) before 1985?		
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
18. Any blood relatives who has or had CJD (Creutzfeldt-Jakob disease)?		
	Yes <input type="checkbox"/> No <input type="checkbox"/>	



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19. Ever received a cell, tissue or organ transplant (cornea, kidney, bone marrow, liver, dura mater, sclera etc)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
20. Had a neurological or brain disorder such as Alzheimer's, Parkinson's or motor neurone disease; or any form of dementia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. Had recent memory loss, confusion, unsteady movements or uncoordinated speech?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

**Heart valve specific questions** *(for the donor only)*

**To the best of your knowledge, has (*donor's name*) ever had a history or evidence of:**

22. endocarditis, myocarditis, rheumatic fever and/or other valvular heart disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
23. congenital or acquired heart disease e.g. previous cardiac surgery, dissecting aortic aneurysm?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Skin specific questions** *(only for donors 10y or older)*

**To the best of your knowledge, has (*donor's name*):**

24. Currently any skin conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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**Eye specific questions** *(only for donors 10y or older)*

**To the best of your knowledge, has (*donor's name*):**

25. Had any vision disorders, eye disorders or diseases, infections, or tumours? (e.g. cataract, glaucoma, retinopathy or corneal disorders)	Yes <input type="checkbox"/> No <input type="checkbox"/>
26. If yes, did this disorder require surgery, (including laser surgery/vision correction of any kind) or clinical treatment by an eye specialist?	Yes <input type="checkbox"/> No <input type="checkbox"/>



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<p>27. There are a number of infections that can be transmitted through tissue transplants. Therefore, we do not take donations from people who are at risk of contracting HIV or hepatitis. (Donor's name)'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 whether it is possible that any of these apply. <i>For children less than 18 months old, or up to 12 months beyond breast feeding (whichever is the greater time) this question applies to the mother of the child.</i></p> <p>Anyone who:</p> <ul style="list-style-type: none"> <li>• has (or had) AIDS or a positive test for HIV or have ever taken any medication to treat an HIV infection.</li> <li>• 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.</li> <li>• carries the Hepatitis B or C virus</li> <li>• ever injected him/herself, even once, with drugs not prescribed by a doctor</li> <li>• has haemophilia or related clotting disorder and has received treatment with plasma derived clotting factor concentrates at any time</li> </ul> <p>Anyone who in the last 3 months:</p> <ul style="list-style-type: none"> <li>• has used any medication to prevent an HIV infection (i.e. pre or post exposure prophylaxis)</li> <li>• (men only) has had oral or anal sex with or without a condom with another man</li> <li>• has engaged in sex work (prostitution) or accepted payment in exchange for sex</li> <li>• has left a country in which they lived and which is considered to be high risk of HIV infection (see map)</li> <li>• has been an inmate of a prison or correctional institution</li> </ul> <p>Anyone who in the last 3 months has had sex with any of the following groups:</p> <ul style="list-style-type: none"> <li>• anyone who lives in or comes from a country considered high risk for HIV infection (see map)</li> <li>• anyone whom you know carries the Hepatitis B or C virus</li> <li>• anyone who has ever injected themselves with drugs not prescribed by a Doctor</li> <li>• anyone with haemophilia or a related blood clotting disorder who has received plasma-derived clotting factor concentrates at any time</li> <li>• a sex worker (prostitute)</li> <li>• (women only) a man who has had oral or anal sex with another man</li> </ul>		
<p><b>To the best of your knowledge, is it possible that any of these apply?</b>      Yes <input type="checkbox"/> No <input type="checkbox"/></p>		

**Final Questions**

28. Can you think of anything else we may need to know about ( <i>donor's name</i> ) before continuing with the donation process?	Yes <input type="checkbox"/> No <input type="checkbox"/>
29. Do you declare that the information provided is correct to the best of your knowledge?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Additional comments</b>	

**Declaration by interviewer**

I, \_\_\_\_\_, confirm that I have taken all reasonable steps to ensure that the history provided here regarding the potential donor is current and accurate to the best of my knowledge, and that the information has been collected in accordance with the Privacy Act 2020 and the Health Information Privacy Code 2020.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Designation: \_\_\_\_\_ Organisation: \_\_\_\_\_

**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: \_\_\_\_\_

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

