

Your logo

Uniform Donor Risk Assessment Interview (Donor >12 years old)

Your address

Donor Name: _____
First Middle Last

Person Interviewed: _____
Name Relationship

Contact Information: _____
Phone Address City State Zip

The interview was conducted: by telephone in person

Person Interviewed: _____
Name Relationship

Contact Information: _____
Phone Address City State Zip

The interview was conducted: by telephone in person

Person conducting interview and completing this form:

Print Name

Signature

Date/Time

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."

1. Where was she/he* born?

2. What was her/his* occupation?

3. Did she/he* have any health problems due to exposure to toxic substances such as pesticides, lead, mercury, gold, asbestos, agent orange, etc.?

- No
- Yes

3a. Describe toxic substance and treatment.

4a. Did she/he* have a family physician or a specialist?

- No
- Yes

4a(i). When was her/his* last visit?

4a(ii). Why?

4a(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):

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<p>4b. Did she/he* use a medical facility such as a clinic or urgent care center?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>4b(i). When was her/his* last visit?</p> <p>4b(ii). Why?</p> <p>4b(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):</p>
<p>5a. Did she/he* take any prescription medication recently or on a regular basis?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>5a(i). What was it and/or what was it used for?</p> <p style="text-align: center;"><i>If a steroid, such as prednisone, ask:</i></p> <p>5a(ii). How long?</p> <p>5a(iii). What was the dose?</p>
<p>5b. Did she/he* take any non-prescribed medication or dietary supplements?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>5b(i). What was it and/or what was it used for?</p>
<p>6. Did she/he* recently have any symptoms such as:</p> <p style="padding-left: 20px;">6a. a fever?</p> <p style="padding-left: 20px;">6b. cough?</p> <p style="padding-left: 20px;">6c. diarrhea?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><i>If any answer in question 6. is "yes," ask "when" this occurred <u>and</u> describe symptoms and reasons," if known.</i></p> <p>6a(i). When?</p> <p>6a(ii). Describe the fever and reasons.</p> <p>6b(i). When?</p> <p>6b(ii). Describe the cough and reasons.</p> <p>6c(i). When?</p> <p>6c(ii). Describe diarrhea and reasons.</p>

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6d. swollen lymph nodes or glands in the neck, armpits or groin?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6d(i). When? 6d(ii). Describe swollen lymph nodes or glands and reasons.
6e. weight loss?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6e(i). When? 6e(ii). Describe how much weight loss and reason(s).
6f. a rash?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6f(i). When? 6f(ii). Describe the rash and reasons.
6g. sores in the mouth or on the skin?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6g(i). When? 6g(ii). Describe the sores and reasons.
6h. night sweats?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6h(i). When? 6h(ii). Describe night sweats and reasons.
6i. severe headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6i(i). When? 6i(ii). Describe the severe headache and reasons.
6j. rapid decline in mental ability?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6j(i). When? 6j(ii). Describe rapid decline in mental ability and reasons.
6k. seizures?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6k(i). When? 6k(ii). Describe seizures and reasons.
6l. tremors?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6l(i). When? 6l(ii). Describe tremors and reasons.
6m. difficulty walking?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6m(i). When? 6m(ii). Describe difficulty walking and reasons.

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<p>7. Did she/he* have any allergies?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>7a. What was she/he* allergic to?</p> <p>7b. Describe reaction:</p>
<p>8. Did she/he* know anyone who had a smallpox vaccination?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>8a. Was that person vaccinated within the past two months?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 8a(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? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 8a(i)a. Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 8a(i)a(i). Explain:
<p>9. In the past 12 months was she/he* bitten or scratched by any pet, stray, farm, or wild animal?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>9a. What kind of animal?</p> <p>9b. When?</p> <p>9c. Did she/he* receive any medical treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 9c(i). By whom?</p>

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		<p>9d. Was the animal suspected of having rabies? <input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>9e. Was the animal quarantined or tested? <input type="checkbox"/>No <input type="checkbox"/>Yes 9e(i). Which one?</p> <p><i>If yes to tested,</i> 9e(ii). What was the result?</p>
<p>10. In the past 12 months was she/he* told by a healthcare professional that they had, or was suspected of having, a West Nile virus infection?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>10a. When was she/he* diagnosed?</p> <p><i>If this occurred within the past 4 months ask:</i> 10a(i). What was the name of the doctor/clinic?</p>
<p>11. In the past 12 months did she/he* have any shots or immunizations, such as for the flu, COVID-19, MMR, yellow fever, hepatitis B, smallpox, etc.?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>11a. When?</p> <p>11b. What kind was it?</p> <p><i>If smallpox/vaccinia is named, ask these questions:</i> 11b(i). Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? <input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i> 11b(i)a. When did these symptoms resolve?</p> <p>11b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>?</p> <p>11b(ii)a. When?</p>
<p>This is a reminder these are standard questions we ask in every interview. Answer to the best of your knowledge with a "Yes" or "No."</p>		
<p>12. In the past 12 months did she/he* get a tattoo, touch up of an old tattoo, or permanent makeup?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>12a. Were shared or non-sterile instruments, needles or ink used? <input type="checkbox"/>No <input type="checkbox"/>Yes</p>

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		<p>12b. Was the procedure performed outside of the United States or Canada?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i> 12b(i). Where?</p>
<p>13. In the past 12 months did she/he* have acupuncture, ear or body piercing?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>13a. Were shared or non-sterile instruments or needles used?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>13b. Was the procedure performed outside of the United States or Canada?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i> 13b(i). Where?</p>
<p>14. In the past 12 months did she/he* live with a person who has hepatitis?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>14a. What type of hepatitis did <u>that person</u> have?</p> <p>14b. 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?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>
<p>15. In the past 12 months did she/he* come into contact with someone else's blood?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>15a. Describe what happened and when:</p> <p>15b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>
<p>16. In the past 12 months did she/he* have an accidental needle-stick?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>16a. Describe what happened and when:</p> <p>16b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>

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. Next, I will ask you about her/his* sexual history.

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17. In the past 12 months did she/he* have a sexually transmitted infection such as syphilis, gonorrhea, chlamydia, genital ulcers, herpes, or genital warts?	<input type="checkbox"/> No <input type="checkbox"/> Yes	17a. What was it?
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For the next part, sexual activity and sex refer to any method of sexual contact including vaginal, anal, and oral. I will read each question and you should answer to the best of your knowledge with a "Yes" or "No."

18. In the past 5 years was she/he* sexually active, even once?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p><i>If yes, complete the following questions (18a. to 18g.)</i></p> <p>For the following set of questions, think about the past 5 years:</p> <p>18a. Did she/he* have sex in exchange for money or drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 18a(i). When?</p> <p>18b. MALE DONOR only: Did he have sex with another male? <input type="checkbox"/> (N/A) Donor is Female</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 18b(i). When?</p> <p>18c. Did she/he* have sex with a person who has had sex in exchange for money or drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 18c(i). When?</p> <p>18d. FEMALE DONOR only: Did she have sex with a male who had sex with another male? <input type="checkbox"/> (N/A) Donor is Male <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 18d(i). When?</p> <p>18e. Did she/he* have sex with a person who used a needle to inject drugs that were not prescribed by their own doctor? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 18e(i). When?</p>
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		<p>18f. Did she/he* have sex with a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><i>If yes,</i> 18f(i). Which virus and when?</p> <p>18f(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?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>
<p>19. Did she/he* EVER use or take drugs, such as steroids, cocaine, heroin, amphetamines, or anything NOT prescribed by her/his* doctor?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>19a. What was it?</p> <p>19b. How often and how long was it used?</p> <p>19c. When was it last used?</p> <p>19d. Were needles used?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><i>If no,</i> 19d(i). How was it taken?</p>
<p>20a. 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?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>20a(i). Explain:</p>
<p>20b. Did she/he* live with, or have sex with, a person who had?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>20b(i). Explain:</p>
<p>21. 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?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>21a. What was she/he* told by a physician?</p>

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<p>22. Was she/he* EVER refused as a blood donor or told not to donate?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>22a. What was the reason?</p>
<p>23. Did she/he* EVER have any kind of surgery?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>23a. What kind?</p> <p>23b. Where?</p> <p>23c. When?</p>
<p>24. Did she/he* EVER travel or live outside of the United States or Canada?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>24a. Where?</p> <p>24b. When and for how long?</p> <p>24c. Did she/he* EVER receive a blood transfusion or other medical treatment outside of the United States or Canada?</p> <p style="margin-left: 20px;"><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="margin-left: 20px;"><i>If yes,</i></p> <p style="margin-left: 40px;">24c(i). What occurred (which one)?</p> <p style="margin-left: 40px;">24c(ii). Describe where and when:</p> <p style="margin-left: 20px;"><i>If international travel or residency is extensive, be aware of query regarding vaccinations or other shots (within the past 12 months) at question #8.</i></p>

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<p>25. Was she/he* EVER a U.S. military member, a civilian military employee, or a dependent of either?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>25a. Did she/he* ever live or work on a U.S. military base outside the United States? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><i>If yes,</i> 25a(i). In which country or countries?</p> <p>25a(ii). When?</p> <p><i>If this occurred between 1980 and 1996 in Europe:</i> 25a(ii)a. How long? (<i>estimate total time</i>)</p> <p><i>If in the military in the past 12 months, be aware of query regarding vaccinations or other shots at question #8.</i></p>
<p>26. Did she/he* EVER use or take growth hormone?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>26a. When was it used?</p> <p>26b. What kind was it?</p>
<p>27. Did she/he* EVER have a positive or reactive test for:</p> <p>27a. the HIV/AIDS virus?</p> <p>27b. hepatitis?</p> <p>27c. HTLV-I or HTLV-II?</p> <p>27d. <i>T. cruzi</i> or told she/he* has Chagas' disease?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>27a(i). Explain:</p> <p>27b(i). Explain:</p> <p>27c(i). Explain:</p> <p>27d(i). Explain:</p>

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28. Did she/he* EVER have liver disease or hepatitis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	28a. What kind? 28b. When?
29. Did she/he* EVER have malaria?	<input type="checkbox"/> No <input type="checkbox"/> Yes	29a. When? 29b. Where was she/he* treated?
30. Was she/he* EVER told by a healthcare professional she/he* was infected with the Ebola Virus?	<input type="checkbox"/> No <input type="checkbox"/> Yes	30a. When was she/he* diagnosed?
31. Did she/he* EVER have cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes	31a. What type? <i>If skin cancer:</i> 31a(i). What kind? 31b. When was it diagnosed? 31c. Describe when and where surgery, radiation, or chemotherapy occurred: 31d. Was the cancer considered cured? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 31d(i). When?
32. Did she/he* EVER smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	32a. What was it? <i>If cigarettes:</i> 32a(i). How many packs per day? 32b. How many years? 32c. Did she/he* quit? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 32c(i). When?

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33a. Did she/he* EVER have lung disease such as asthma, COPD, or emphysema?	<input type="checkbox"/> No <input type="checkbox"/> Yes	33a(i). Explain:
33b. Did she/he* EVER have tuberculosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	33b(i). When was she/he* diagnosed? 33b(ii) Did she/he* receive treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, when, and how long?</i>
33c. Did she/he* EVER have a positive skin or blood test for tuberculosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	33c(i). What test was positive and when? 33c(ii). Did she/he* receive treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, when, and how long?</i>
33d. Did she/he* EVER live with or spend time with a person who had tuberculosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	33d(i) Describe the circumstances 33d(ii) When?
34. Did she/he* EVER drink alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	34a. What type? 34b. How often? 34c. How much? 34d. How long?
35. Did she/he* EVER have diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes	35a. For how many years? 35b. Was it treated? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 35b(i). How?

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36a. Did she/he* EVER have kidney disease, kidney stones, or frequent kidney infections?	<input type="checkbox"/> No <input type="checkbox"/> Yes	36a(i). What did she/he* have? 36a(ii). When?
36b. Was she/he* EVER treated with dialysis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	36b(i). If treated with dialysis, was it peritoneal dialysis or hemodialysis? 36b(ii). Since when?
37. Did he/she* EVER have high blood pressure or high cholesterol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	37a. Which one (or both)? 37b. For how many years?
38. Did she/he* EVER have a heart attack or heart disease, such as a weak heart, a heart valve problem or an infection involving the heart?	<input type="checkbox"/> No <input type="checkbox"/> Yes	38a. Explain: 38b. How was it treated?
39. Did she/he* EVER have circulation problems of the legs, such as varicose veins, blood clots, leg ulcers, or skin discoloration of the feet or ankles?	<input type="checkbox"/> No <input type="checkbox"/> Yes	39a. Explain:
40. Did she/he* EVER have an autoimmune disease such as systemic lupus erythematosus, rheumatoid arthritis, sarcoidosis, etc.?	<input type="checkbox"/> No <input type="checkbox"/> Yes	40a. What was it? 40b. Did she/he* take steroids? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, complete 5a(ii) and 5a(iii).</i>
41. Did she/he* EVER have any eye problems, procedures, or surgery?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>If yes to eye problems:</i> 41a. What kind of eye problems? <i>If yes to eye surgery or procedures:</i> 41b. What kind of surgery or procedure was performed and why?

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		<p>41c. Which eye(s)?</p> <p><input type="checkbox"/> left</p> <p><input type="checkbox"/> right</p> <p><input type="checkbox"/> unknown</p> <p>41d. What is the name and/or phone number of her/his* eye doctor or eye clinic?</p>
<p>42. Did she/he* or any of her/his* relatives have Creutzfeldt-Jakob disease, which is also called CJD or variant CJD?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>42a. Who did?</p> <p><i>If a relative,</i> 42a(i). Is this person a blood relative? <i>(Note: The definition of blood relative is a person who is related through a common ancestor and not by marriage or adoption)</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><i>If yes,</i> 42a(i)a. Which blood relative?</p> <p>42b. Is there a physician, relative, or other person who can provide more information? <i>(document discussion)</i></p>
<p>43a. Did her/his* family have a history of diabetes?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>43a(i). Describe type of relative, such as mother, father, sister, brother, etc.:</p>
<p>43b. Did her/his* family have a history of coronary artery disease, which is a buildup of plaque in the heart's arteries?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>43b(i). Describe type of relative, such as mother, father, sister, brother, etc.:</p>
<p>44. Did she/he* EVER live in a homeless shelter?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>44a. When?</p> <p>44b. Describe the situation</p> <p>44c. How long?</p>

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45. Was she/he* EVER in lockup, jail, prison, or any juvenile correctional facility?	<input type="checkbox"/> No <input type="checkbox"/> Yes	45a. When? 45b. Where? 45c. For how long?
<i>Final Questions</i>		
46. Are there other medical conditions you are aware of that we have not discussed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	46a. Describe:
47. Do you now have any concerns that her/his* donation should not proceed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	47a. Can you share your concerns?
48. Regarding these questions, are there other people, including healthcare professionals, who may provide additional information?	<input type="checkbox"/> No <input type="checkbox"/> Yes	48a. Name(s) and contact information:
49. Do you have any questions about these questions?	<input type="checkbox"/> No <input type="checkbox"/> Yes	49a. Document:
<i>Note to interviewer: Question 50, the HIV-1 Group O Risk Question, must be asked if the test kit being used for HIV-1 Ab testing is not labeled to include HIV-1 Group O. Check here if question skipped <input type="checkbox"/>.</i>		
50. Did she/he* EVER have sex with a person who was born in or lived in any country in Africa?	<input type="checkbox"/> No <input type="checkbox"/> Yes	50a. When was the person born, or when did the person live, in Africa? <i>If since 1977:</i> 50a(i). What country were they from?

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Additional Notes