



Mater Misericordiae University Hospital

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IRISH DONOR NO: _____

DATE: _____

Name & Title of Person Taking History: _____

Donor Coordinator Responsible: _____

Donor Name _____ **DOB** _____ **Sex** M F

Donor Hospital _____

Type of Donor: Brain Death Non-heart beating donor Living

CAUSE OF DEATH: Main Diagnoses.

1. _____

2. _____

3. _____

QUESTIONNAIRE

Many of these questions can be reliably answered from the Medical History in the clinical notes and need not be asked of the relatives. If the answer is derived from the Medical History in the clinical notes rather than asking the relative, mark 'MH' beside the answer.

If the answer to any of the questions is Yes, please provide details; if not enough space, write at the end of the questionnaire.

“Some of these questions are of a personal and sensitive nature. They are similar to those asked when someone donates blood. We ask these questions of everyone to help determine the suitability of the organs for donation. I will read each question and you should answer to the best of your knowledge. You may be asked to comment and elaborate on some questions. All the information you share is treated in a strictly confidential manner”.



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MEDICAL HISTORY

1. History of high blood pressure Yes No
2. History of diabetes mellitus Yes No
3. History of smoking? Yes No If yes Cigs / day _____
4. History of alcohol? Yes No If yes Units / week _____
5. Previous spinal or neurological surgery? Yes No
6. Previous abdominal or chest surgery? Yes No
7. Any surgery in the UK since 1980? Yes No
8. Any history of blood/blood products transfusion? Yes No
9. Any history of haemophilia or related disease which required transfusion with coagulation factors? Yes No
10. Any history of drug or substance abuse? Yes No
- If YES, please give details; _____
11. Any history of ingesting or exposure to a substance such as gold, cyanide lead and mercury Yes No
12. Any history of autoimmune disease? (i.e. Rheumatoid arthritis, Ulcerative colitis, Crohn's disease, Psoriasis, Coeliac Disease, Multiple Sclerosis, Myasthenia gravis, Sarcoidosis, Polyarteritis Nodosa, SLE, Rheumatic fever) Yes No
-
13. History of kidney disease? Yes No
14. History of heart disease (e.g. cardiomyopathy) Yes No
15. History of liver disease ? Yes No
16. History of disease or infection of heart valves? Yes No
17. History of respiratory disease? Yes No
18. Previous history of cancer? Yes No
19. Any long-term treatments? Yes No
20. Any history of Creutzfeldt-Jakob disease in the patient or in the family? Yes No



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21. Any history of dementia or neurological disease of unknown cause?
Yes No

22. Have they received hormones derived from human pituitary gland or any other human tissue e.g. grafts of cornea, sclera, dura mater or any organ or tissue transplant?
Yes No

23. History of vaccinations apart from usual childhood ones? Yes No

24. Has the donor currently any significant infection (e.g. septicaemia, viral disease, syphilis, active tuberculosis, systemic fungal disease, malaria Chagas disease)?
Yes No

25. Any history or any clinical evidence or any confirmed positive laboratory tests for HIV infection (AIDS), hepatitis B, hepatitis C infection or HTLV I/II infection?
Yes No

SOCIAL HISTORY

“To allow us to carry out a risk assessment for infectious diseases, we would be grateful if you could answer the following questions to the best of your knowledge. Unfortunately these are somewhat intrusive and we regret that”

1. Did he/she travel outside Ireland in the last year? Yes No
If yes, please give details _____

2. Did he/she ever live or work outside the Republic of Ireland? Yes No
If yes, please give details _____

3. Did he/she receive any tattoos, body-piercing or acupuncture during the last year?
Yes No

4. If the answer to the previous question is YES, do you know whether or not sterilised needles were used? Yes No

5. Has he/she ever taken any substances from ‘head shops’?
Yes No



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6. Did he/she ever spend time in prison? Yes No
7. Did he/she ever inject any illegal drugs? Yes No
8. To your knowledge did they have sexual relations with more than one partner in the last 12 months? Yes No
9. (If male) To your knowledge did they ever have sexual relations with a male partner? Yes No
10. Is it possible he/she ever had sex in order to obtain money or drugs? Yes No
11. Is it possible he/she ever had sexual relations with partners known to have AIDS or hepatitis? Yes No
12. Was he/she treated for syphilis or gonorrhoea in the last 12 months? Yes No

Is there anyone else who you think could provide more information about the questions we just asked? Yes No

If yes, please specify Name and Relationship to deceased:

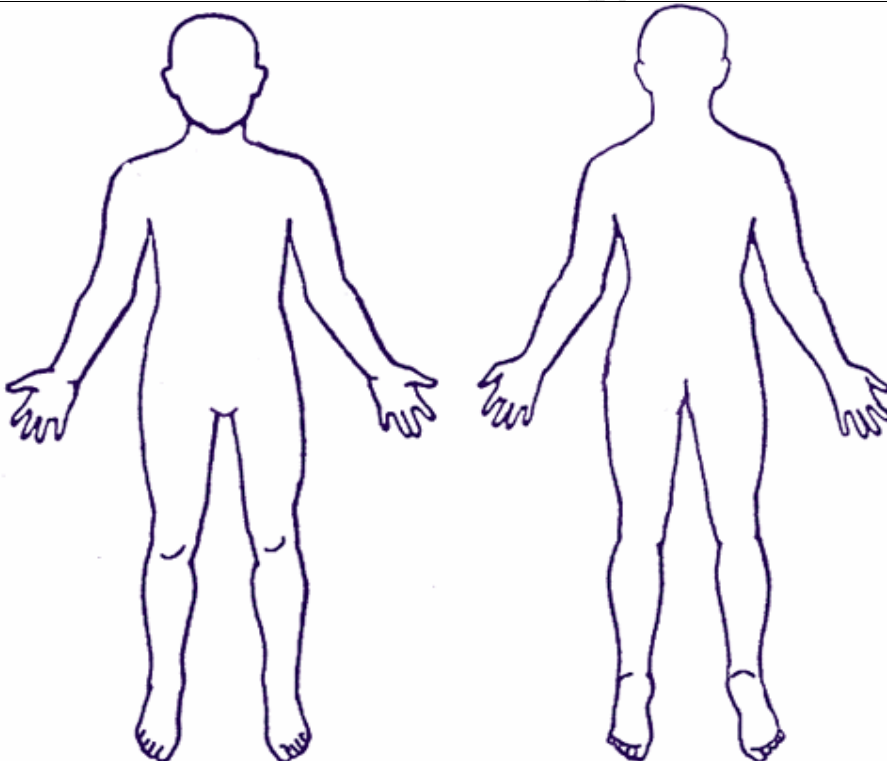


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PHYSICAL EXAMINATION

- | | |
|--|--|
| • Tattoos | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Body Piercings | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Scars | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Tumours | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Non-therapeutic venepunctures | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Traumatic injuries | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Condyloma (external genitalia, anus) | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Jaundice | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Adenopathy | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| • Other | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If the answer to any of the above is YES, please indicate them on the body diagram below:





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Any Additional Information/Observations:

Person Interviewed: _____

Relationship to the deceased: _____

Signed (interviewee): _____

Signed (interviewer): _____ **Title** _____

Signed: _____

Time and Date: _____

CONTROLLED DOCUMENT