

Your logo

Uniform Donor Risk Assessment Interview

Birth Mother

Your address

Child Donor's Name: _____
First Middle Last

Birth Mother's Name: _____
First Middle Last

Person Interviewed: _____
Name Relationship to Birth Mother

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."

Check if the Uniform DRAI for the Birth Mother is the only DRAI that will be completed. This circumstance occurs only when the child donor has not left the hospital since birth. See Question #27.

1. Where were you (was she*) born?

2a. Did you (she*) have a family physician or a specialist?

No
 Yes

2a(i). When was your/her* last visit?

2a(ii). Why?

2a(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):

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Uniform Donor Risk Assessment Interview Birth Mother

<p>2b. Did you (she*) use a medical facility such as a clinic or urgent care center?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>2b(i). When was your (her)* last visit?</p> <p>2b(ii). Why?</p> <p>2b(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.):</p>
<p>3. Did you/she* recently have any symptoms such as:</p> <p style="margin-left: 20px;">3a. a fever?</p> <p style="margin-left: 20px;">3b. cough?</p> <p style="margin-left: 20px;">3c. diarrhea?</p> <p style="margin-left: 20px;">3d. swollen lymph nodes or glands in the neck, armpits or groin?</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><i>If any answer in question 3. is "yes," ask "when" this occurred <u>and</u> "describe symptoms and reasons," if known.</i></p> <p>3a(i). When? 3a(ii). Describe the fever and reasons.</p> <p>3b(i). When? 3b(ii). Describe the cough and reasons.</p> <p>3c(i). When? 3c(ii). Describe diarrhea and reasons.</p> <p>3d(i). When? 3d(ii). Describe swollen lymph nodes or glands and reason.</p>

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Uniform Donor Risk Assessment Interview Birth Mother

		<p>5b. When?</p> <p>5c. Did you (she*) receive any medical treatment? <input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i> 5c(i). By whom?</p> <p>5d. Was the animal suspected of having rabies? <input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>5e. Was the animal quarantined or tested? <input type="checkbox"/>No <input type="checkbox"/>Yes 5e(i). Which one? <i>If yes to tested,</i> 5e(ii). What was the result?</p>
<p>6. In the past 12 months were you (was she*) told by a healthcare professional that you/she* had a West Nile virus infection?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>6a. When were you (was she*) diagnosed?</p> <p style="text-align: center;"><i>If this occurred within the past 4 months ask:</i> 6a(i). What was the name of the doctor/clinic?</p>
<p>7. In the past 12 months did you/she* have any shots or immunizations, such as for the flu, MMR, yellow fever, hepatitis B, etc.?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>7a. When?</p> <p>7b. What kind was it?</p> <p style="text-align: center;"><i>If smallpox/vaccinia is named, ask these questions:</i></p> <p>7b(i). Did you/she* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? <input type="checkbox"/>No</p>

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Uniform Donor Risk Assessment Interview Birth Mother

		<p style="text-align: center;"><input type="checkbox"/>Yes <i>If yes,</i> 7b(i)a. When did these symptoms resolve?</p> <p style="text-align: center;">7b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>?</p> <p style="text-align: center;">7b(ii)a. When?</p>
<p>This is a reminder these are standard questions we ask in every interview.</p> <p>Answer to the best of your knowledge with a “Yes” or “No.”</p>		
<p>8. In the past 12 months did you/she* get a tattoo, touch up of an old tattoo, or permanent makeup?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>8a. Were shared or non-sterile instruments, needles or ink used?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>8b. 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> 8b(i). Where?</p>
<p>9. In the past 12 months did you/she* have acupuncture, ear or body piercing?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>9a. Were shared or non-sterile instruments or needles used?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>9b. 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> 9b(i). Where?</p>

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Uniform Donor Risk Assessment Interview Birth Mother

<p>10. In the past 12 months did you/she* live with a person who has hepatitis?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>10a. What type of hepatitis did that person have?</p> <p>10b. 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> <input type="checkbox"/> No <input type="checkbox"/> Yes
<p>11. In the past 12 months did you/she* come into contact with someone else's blood?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>11a. Describe what happened and when:</p> <p>11b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes
<p>12. In the past 12 months did you/she* have an accidental needle-stick?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>12a. Describe what happened and when:</p> <p>12b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis?</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 questions about sexual history.</p>		
<p>13. In the past 12 months did you/she* have a sexually transmitted infection such as syphilis, gonorrhea, chlamydia, or genital ulcers, herpes, or genital warts?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>13a. What was it?</p>

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Uniform Donor Risk Assessment Interview Birth Mother

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."

<p>14. The following questions relate to the past 5 years:</p> <p>14a. Did you/she* have sex in exchange for money or drugs?</p> <p>14b. Did you/she* have sex with a person who has had sex in exchange for money or drugs?</p> <p>14c. Did you/she* have sex with a male who had sex with another male?</p> <p>14d. Did you/she* have sex with a person who used a needle to inject drugs that were not prescribed by their own doctor?</p> <p>14e. Did you/she* have sex with a person who has received medication for a bleeding disorder such as hemophilia?</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><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>14a(i). When?</p> <p>14b(i). When?</p> <p>14c(i). When?</p> <p>14d(i). When?</p> <p>14e(i). Do you know the name of the medication? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 14e(i)a. What was it?</p>
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Uniform Donor Risk Assessment Interview Birth Mother

<p>14f. Did you/she* have sex with a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>14e(ii). Was the medication human derived? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>14e(iii) When was it used?</p> <p>14f(i). Which virus and when?</p> <p>14f(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? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>15. In the past 5 years, did you/she* receive medication for a bleeding disorder such as hemophilia?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>15a. When?</p> <p>15b. What was the reason?</p> <p>15c. Do you know the name of the medication? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 15c(i). What was it?</p> <p>15d. Was the medication human derived? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>

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Uniform Donor Risk Assessment Interview Birth Mother

<p>16. Did you/she* EVER use or take drugs, such as steroids, cocaine, heroin, amphetamines, or anything NOT prescribed by your/her* doctor?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>16a. What was it?</p> <p>16b. How often and how long was it used?</p> <p>16c. When was it last used?</p> <p>16d. Were needles used?</p> <p style="margin-left: 20px;"><input type="checkbox"/> No</p> <p style="margin-left: 20px;"><input type="checkbox"/> Yes</p> <p style="margin-left: 20px;"><i>If no,</i></p> <p style="margin-left: 20px;">16d(i). How was it taken?</p>
<p>17a. Did you/she* EVER have a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>17a(i). Explain:</p>
<p>17b. Did you/she* live with, or have sex with, a person who had?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>17b(i). Explain:</p>
<p>18. Were you (was she*) EVER refused as a blood donor or told not to donate?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>18a. What was the reason?</p>

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Uniform Donor Risk Assessment Interview Birth Mother

<p>19. Did you/she* EVER travel or live outside of the United States or Canada?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>19a. Where?</p> <p>19b. When and for how long?</p> <p><i>If international travel or residency is extensive, be aware of query regarding vaccinations or other shots (within the past 12 months) at question #7.</i></p>
<p>20. Did you/she* EVER have a positive or reactive test for:</p> <p style="margin-left: 20px;">20a. the HIV/AIDS virus?</p> <p style="margin-left: 20px;">20b. hepatitis?</p> <p style="margin-left: 20px;">20c. HTLV-I or HTLV-II?</p> <p style="margin-left: 20px;">20d. <i>T. cruzi</i> or told you have (she* 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>20a(i). Explain:</p> <p>20b(i). Explain:</p> <p>20c(i). Explain:</p> <p>20d(i). Explain:</p>

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Uniform Donor Risk Assessment Interview Birth Mother

21. Did you/she* EVER have liver disease or hepatitis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	21a. What kind? 21b. When?
22. Did you/she* EVER have malaria?	<input type="checkbox"/> No <input type="checkbox"/> Yes	22a. When? 22b. Where were you (was she*) treated?
23. Were you (was she*) EVER treated with dialysis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	23a. If treated with dialysis, was it peritoneal dialysis or hemodialysis? 23b. When?
<i>Final Questions</i>		
24. Do you (Does she)* have other medical conditions that we have not discussed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	24a. Describe:
25. Regarding these questions about you/her*, are there other people, including healthcare professionals, who may provide additional information?	<input type="checkbox"/> No <input type="checkbox"/> Yes	25a. Name(s) and contact information:

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Uniform Donor Risk Assessment Interview Birth Mother

26. Do you have any questions about these questions?	<input type="checkbox"/> No <input type="checkbox"/> Yes	26a. Document:
<i>Note to interviewer: Question 27 must be asked if the child donor has not left the hospital since birth and a "Uniform DRAI - Child donor ≤12 years old" will not be completed. Check here if this question is skipped <input type="checkbox"/>.</i>		
27. Did any of your child's relatives have Creutzfeldt-Jakob disease, which is also called CJD?	<input type="checkbox"/> No <input type="checkbox"/> Yes	27a. Who did? 27a(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>) <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 27a(i)a. Which blood relative?
<i>Note to interviewer: Questions 28a & 28b, the HIV-1 Group O Risk Questions, 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 these questions are skipped <input type="checkbox"/>.</i>		
28a. Did you/she* EVER have sex with a person who was born in or lived in a country in Africa?	<input type="checkbox"/> No <input type="checkbox"/> Yes	28a(i). When was the person born, or when did the person live, in Africa? <i>If since 1977:</i> 28a(ii). What country in Africa were they from?

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