HUNTSMAN CANCER INSTITUTE UNIVERSITY OF UTAH

# Donor Screening Questionnaire

## Utah Blood and Marrow Transplant Program

UNIVERSITY OF UTAH HEALTH CARE

Please answer these questions as completely as possible. The information is important because donors at risk for diseases can pass these diseases to patients receiving their cells. The potential donor **must** complete this questionnaire. No one else may complete it in the donor's place.

Name _____ Medical Record Number (MRN) _____ Date _____

Address _____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone _____

(Please include the area code with all phone numbers and put a star by the best number to reach you.)

E-mail address _____

Age _____ Date of Birth _____ Occupation (optional) _____

Height _____ ❒ ft/in ❒ m/cm Weight _____ ❒ lbs ❒ kg Gender ❒ M ❒ F

### Instructions

- Answer each question to the best of your knowledge.
- Mark your responses clearly.
- For question 1, please explain a "No" response. For all other questions, explain any "Yes" response in the space provided.
- Your answers to all questions are confidential. We share this ihnformation only as needed for medical reasons. By signing this document, you give written consent to share it. This protects you and the patient who may receive your donated stem cells.
- If you have questions, please discuss them with the Blood and Marrow Transplant team.

### Section 1: General Assessment and Donor Safety

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| 1. Are you in good health? _____ | Yes ❒ No ❒ |
| 2. Do you have an infection now, or are you currently taking antibiotics? _____ | Yes ❒ No ❒ |
| 3. Are you currently taking any other medication, including over-the-counter medications, vitamins, herbal products, or investigational drugs? Please list them and state why you take them. _____ | Yes ❒ No ❒ |

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| 4. In the past 12 months, have you needed treatment in an emergency room, been hospitalized, or had surgery? | Yes ☐ No ☐ |
| 5. In the past 12 months, have you received a blood transfusion or a tissue transplant, including cornea or bone? | Yes ☐ No ☐ |
| 6. Have you ever had a blood transfusion from a source other than your own blood? | Yes ☐ No ☐ |
| **Questions 7–10 are for female donors only. If you are male, please skip to question 11.** | |
| 7. Is there any chance you will become pregnant within the next six months? | Yes ☐ No ☐ |
| 8. Have you ever been pregnant? **If No, please skip to question 11.** If Yes, please write the number of pregnancies. _____ | Yes ☐ No ☐ |
| 9. In the past six weeks, have you been pregnant or are you now pregnant? | Yes ☐ No ☐ |
| 10. Have you had any health problems associated with or caused by pregnancy? | Yes ☐ No ☐ |
| 11. Have you ever received or donated an organ, bone marrow, or stem cells? | Yes ☐ No ☐ |
| 12. Have you ever had problems with general or regional anesthesia? (General anesthesia means you were completely unconscious. Regional anesthesia means you were conscious, but pain responses from part of your body were blocked.) | Yes ☐ No ☐ |
| 13. Have any of your blood relatives had problems with anesthesia? If yes, list the relatives and the problem. | Yes ☐ No ☐ |
| 14. Do you have any allergies to foods, drugs, latex, or environmental allergens such as pollen? If yes, please list them. | Yes ☐ No ☐ |


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| 15. Have you ever had neck, back, hip, or spine problems? If yes, please describe your current status, treatments, and any related surgeries. | Yes ☐<br>No ☐ |
| 16. Have you ever had breathing problems, including asthma, sleep apnea, or shortness of breath? | Yes ☐<br>No ☐ |
| 17. Have you ever had a stroke, heart attack, heart-related chest pains, heart disease, or heart surgery? | Yes ☐<br>No ☐ |
| 18. Have you ever had cancer, including leukemia? | Yes ☐<br>No ☐ |
| 19. Have you ever had a parasitic blood disease, such as leishmaniasis or babesiosis? | Yes ☐<br>No ☐ |
| 20. In the past four weeks, have you had any vaccinations (except smallpox) or any kind of shot? | Yes ☐<br>No ☐ |
| 21. Are you planning to receive any vaccinations (including smallpox) or shots? | Yes ☐<br>No ☐ |
| 22. In the past three years, have you had malaria? | Yes ☐<br>No ☐ |
| 23. In the past three years, have you *lived* outside the United States or Canada for 12 months or more? If yes, please list where, when, and for how long. Include dates (month/year), cities, countries, and modes of transportation you used (for example, car or plane) while in the countries. Note if you took anti-malaria medication. Note if you were sick at all while you were there or after you returned to the United States. If so, what were your symptoms, and did you seek medical attention? | Yes ☐<br>No ☐ |


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| 24. In the past 12 months, have you *traveled* outside the United States or Canada for less than 12 months? Please list where, when, and for how long. Include dates (month/year), cities, countries, and modes of transportation you used (for example, car or plane) while in the countries. Note if you took anti-malaria medication. Note if you were sick at all while you were there or after you returned to the United States. If so, what were your symptoms, and did you seek medical attention? _____ | Yes ☐ No ☐ |
| 25. Is there any other past or present health information you think we should be aware of? Examples include past surgeries or serious medical conditions such as a head or brain injury, diabetes, fibromyalgia, blood clots, or an autoimmune disorder such as multiple sclerosis, iritis, episcleritis, or lupus. _____ | Yes ☐ No ☐ |

**Section 2: Communicable Disease Assessment**

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| 26. In the past four months, have you had a positive test for West Nile virus? _____ | Yes ☐ No ☐ |
| 27. Have you ever been told by a health care professional that you had or might have had West Nile virus? If Yes, when were you told this? _____ | Yes ☐ No ☐ |
| 28. In the past eight weeks, have you received a smallpox vaccination? **If Yes, please answer questions 28A – 28C. If No, skip to question 29.** | Yes ☐ No ☐ |
| 28A. When did you receive the vaccination? _____ | |
| 28B. Has the vaccination scab fallen off your skin by itself? | Yes ☐ No ☐ |
| 28C. Did you have any illness or complications due to the vaccination such as an eye infection or a rash, an allergic reaction, or sores away from the vaccination site? _____ | Yes ☐ No ☐ |
| 29. Have you had close contact with the vaccination site of anyone who has received the smallpox vaccine in the past three months? **If Yes, please answer questions 29A - 29C. If No, skip to question 30.** | Yes ☐ No ☐ |
| 29A. When did the person receive the vaccination? _____ | |
| 29B. When was the close contact? _____ | |
| 29C. Have *you* had any new skin rash, sores, or eye infection since the time of contact? _____ | Yes ☐ No ☐ |
| 30. Have you been diagnosed with Creutzfeldt-Jakob Disease (CJD) or variant CJD? _____ | Yes ☐ No ☐ |
| 31. Have any of your blood relatives been diagnosed with Creutzfeldt-Jakob disease, or have you been told that your family has an increased risk for this disease? _____ | Yes ☐ No ☐ |


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| 32. Do you have a degenerative neurological condition such as dementia or any other disease of the central nervous system where the cause is unknown? | Yes ❒ No ❒ |
| 33. Have you ever had a dura mater (or brain covering) transplant for a head or brain injury? | Yes ❒ No ❒ |
| 34. Have you ever received growth hormone made from human pituitary glands? | Yes ❒ No ❒ |
| 35. Have you ever had Chagas Disease or any positive tests for Chagas or *T. cruzi*, including screening tests? | Yes ❒ No ❒ |
| 36. Do you have HIV or AIDS or have you ever tested positive for the virus, including screening tests? | Yes ❒ No ❒ |
| 37. Do you have any of the following conditions? Please check all that apply.<br>❒ *unexplained* weight loss, night sweats, or persistent diarrhea<br>❒ *unexplained* persistent cough or shortness of breath<br>❒ *unexplained* persistent white spots or unusual sores in the mouth<br>❒ *unexplained* temperature higher than 100.5°F (38.0°C) for more than 10 days<br>❒ blue or purple spots on or under the skin or mucous membranes<br>❒ lumps in the neck, armpits, or groin lasting longer than one month | |
| 38. Have you ever had a bleeding problem such as hemophilia or other clotting factor deficiency, or have you received human-derived clotting factor concentrates? | Yes ❒ No ❒ |
| 39. Have you ever tested positive for Human T-lymphotropic virus (HTLV), including screening tests? | Yes ❒ No ❒ |
| 40. Since the age of 11 years, have you ever tested positive for hepatitis, including screening tests, or have you ever had yellow jaundice, liver disease, or hepatitis? | Yes ❒ No ❒ |
| 41. Have you ever tested positive for syphilis, including screening tests, or ever been treated for syphilis? | Yes ❒ No ❒ |
| 42. Have you, any of your sexual partners, or any members of your household ever had a xenotransplant or a medical procedure that involved being exposed to live cells, tissues, or organs from an animal? | Yes ❒ No ❒ |
| 43. In the past 12 months, have you had a tattoo? Provide date of tattoo application and if you have any signs of infection. Note if performed in licensed establishment. | Yes ❒ No ❒ |
| 44. In the past 12 months, have you had an ear, skin, or body piercing using shared instruments or needles? | Yes ❒ No ❒ |


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| 45. In the past 12 months, have you had an accidental needle stick or come into contact with someone else's blood through an open wound, non-intact skin (for example, a cut or sore), or mucous membrane (for example, into your eye or mouth)? | Yes ☐ No ☐ |
| 46. In the past 12 months, have you lived with or had sexual contact with anyone having yellow jaundice or hepatitis, or have you received Hepatitis B Immune Globulin (HBIG)? | Yes ☐ No ☐ |
| 47. In the past 12 months, have you had sex, even once, with anyone who has used, in the past five years, a needle to take drugs, steroids, or anything else not prescribed by a doctor? | Yes ☐ No ☐ |
| 48. In the past 12 months, have you given money, drugs, or other payment for sex OR have you had sex, even once, with anyone who has, in the past five years, taken money, drugs, or other payment in exchange for sex? | Yes ☐ No ☐ |
| 49. In the past 12 months, have you had sex, even once, with anyone who has taken, in the past five years, human-derived clotting factors? | Yes ☐ No ☐ |
| 50. In the past 12 months, have you had sex, even once, with anyone who has HIV or AIDS or tested positive for the virus? | Yes ☐ No ☐ |
| 51. In the past 12 months, have you been held in a jail, prison, juvenile detention, or lockup for more than 72 continuous hours? | Yes ☐ No ☐ |
| 52. FEMALE DONORS ONLY. **If male, please skip to question 53.** In the past 12 months, have you had sex with a male who has had sex, even once, with another male in the past five years? | Yes ☐ No ☐ |
| 53. MALE DONORS ONLY. **If female, please skip to question 54.** In the past five years, have you had sex, even once, with another male? | Yes ☐ No ☐ |
| 54. In the past five years, have you taken money, drugs, or other payment in exchange for sex? | Yes ☐ No ☐ |
| 55. In the past five years, have you used a needle, even once, to take drugs, steroids, or anything else not prescribed by a doctor? | Yes ☐ No ☐ |
| 56. Since 1977, were you born in or have you lived in Africa? **If Yes, please answer questions 56A and 56B. If No, skip to question 57.** | Yes ☐ No ☐ |
| 56A. Were you in Benin, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Kenya, Niger, Nigeria, Senegal, Togo, or Zambia? **If Yes, please list country or countries where you lived.** | Yes ☐ No ☐ |
| 56B. Did you receive a blood transfusion or medical treatment with a blood product while there? | Yes ☐ No ☐ |
| 57. Have you had sex with anyone who, since 1977, was born in or lived in Africa? **If Yes, please answer question 57A. If No, skip to question 58.** | Yes ☐ No ☐ |


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57A. Was the person born in or did they live in Benin, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Kenya, Niger, Nigeria, Senegal, Togo, or Zambia? Yes ❒ No ❒

58. Since 1980 to the present, have you ever lived in or traveled to any countries in Europe listed below? Yes ❒ No ❒

| | | | |
|---|---|---|---|
| Albania | France | Netherlands (Holland) | Switzerland |
| Austria | Germany | Norway | United Kingdom: England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, Falkland Islands |
| Belgium | Greece | Poland | |
| Bosnia-Herzegovina | Hungary | Portugal | |
| Bulgaria | Ireland | Romania | |
| Croatia | Italy | Slovak Republic | |
| Czech Republic | Liechtenstein | Slovenia | Yugoslavia (Federal Republic) Kosovo, Montenegro, Serbia |
| Denmark | Luxembourg | Spain | |
| Finland | Macedonia | Sweden | |

**If Yes, please answer questions 58A - 58C. If No, skip to question 59.**

58A. From 1980 through 1996, did you spend time that adds up to three months or more in the United Kingdom (UK)? See list of UK countries above. Yes ❒ No ❒

58B. Since 1980, did you receive a transfusion of blood or blood components while in the UK or France? Yes ❒ No ❒

58C. Since 1980, have you spent time that adds up to five years or more in Europe, including time spent in the UK between 1980 and 1996? Yes ❒ No ❒

59. From 1980 through 1996, were you a member of the U.S. military or their dependent or a civilian military employee or their dependent? **If Yes, please answer questions 59A and 59B. If No, skip to question 60.** Yes ❒ No ❒

59A. Did you spend a total of six months or more between 1980 and 1990 at a military base in Belgium, Netherlands, or Germany? Yes ❒ No ❒

59B. Did you spend a total of six months or more between 1980 and 1996 at a military base in Spain, Portugal, Turkey, Italy, or Greece? Yes ❒ No ❒

60. In the past 6 months, have you traveled to or lived in a risk area for the Zika virus? Please check the Centers for Disease Control (CDC) website for the current list of risk areas: www.cdc.gov/zika/geo/active-countries. **If Yes, please list areas and dates**. Yes ❒ No ❒

61. In the past 6 months, have you been diagnosed with the Zika virus? **If Yes, what was the date of diagnosis?** Yes ❒ No ❒

62. In the past 6 months, have you had sex with a person who:

62A. Was diagnosed with Zika virus within 6 months of the sexual contact? Yes ❒ No ❒

- ❒ I don't know
- ❒ I don't know, but I will find out.

62B. Traveled to or resided in a risk area in the 6 months before the sexual contact? Yes ❒ No ❒

- ❒ I don't know
- ❒ I don't know, but I will find out.


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**IMPORTANT: DONORS, PLEASE SKIP SECTION 3.**

**CONTINUE TO SECTION 4 TO COMPLETE THIS QUESTIONNAIRE.**

**Section 3: BMT Advanced Practice Provider (APP)/Physician Review**

3A. I reviewed this form for completeness. Information affecting donation was assessed and my evaluation is documented where necessary. If further assessment was required, I notified appropriate staff.

I completed the form by the following method:

❑ 3A.1 I performed an oral interview with the donor (including reading Section 4) and completed this form. *Complete Section 3C if interpreter was used during interview.*

❑ 3A.2 The donor self-administered this form, and I reviewed the recorded information. *Complete Section 3B (before donor clearance) if at workup stage.*

APP/Physician Signature _____ Date _____

If at workup and 3A.2 is marked, complete this section before donor clearance.

3B. I reviewed and verbally verified answers with the donor. I addressed any questions the donor had and clarified health information, as needed, to perform the assessment.

APP/Physician Signature _____ Date _____

3C. I used a translation service or interpreter.

Name of service or interpreter _____

**PLEASE GO TO THE NEXT PAGE AND COMPLETE SECTION 4 TO FINISH THIS QUESTIONNAIRE.**



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**Section 4: Donor Verification and Authorization**

- I have truthfully answered all of the questions on this questionnaire.
- I have had the opportunity to ask questions about the information requested on this questionnaire.
- I understand that the requested information is important. If I am at risk for any communicable diseases, my donated cells could pass these diseases to the patient receiving them.
- I consent to the release of my health information to be shared with the recipient as deemed appropriate by a physician of the Utah Blood and Marrow Transplant Program. Furthermore, I authorize this information to be posted to the recipient's Electronic Medical Record (EMR). The health information shared and posted would be limited to that relevant to the medical care of the intended recipient such as infectious disease markers.
- I understand that any information identifying me will remain confidential. I also understand that the potential recipient of my donation may be advised of any communicable disease risks.
- I understand that authorizing this release of information is voluntary and that I can refuse to sign this document.

By signing I acknowledge that I have read, understand, and agree with the above.

Donor signature _____ Date _____

Donor name (please print) _____