

Your logo

# Uniform Donor Risk Assessment Interview Child 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. What was her/his\* date of birth?

*Date of Birth:* \_\_\_\_\_

*Interviewer calculates the donor's age:* \_\_\_\_\_

- If ≤18 months old, complete the Uniform DRAI (Birth Mother) in addition to this form.
- If <5 years old, ask question 1a:

1a. Within the past 12 months, was she/he\* breastfed or was she/he\* fed breast milk from another person?

No

Yes

*If yes, ask:*

1a(i). Who provided the breast milk? \_\_\_\_\_

- If this is the birth mother, complete the Uniform DRAI (Birth Mother) in addition to this form.

*Check which Uniform DRAI form(s) will be completed:*

Uniform DRAI (Child Donor ≤12 years old)

Uniform DRAI (Birth Mother)

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<b>2.</b> Where was she/he* born?		
<b>3.</b> Did she/he* have any illnesses or ongoing problems with health, such as:		<i>If any answer in question 3. is "yes," further questioning is required.</i>
<b>3a.</b> lung disease such as asthma, cystic fibrosis, or tuberculosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	3a(i). Explain: 3a(ii): If tuberculosis, when was she/he* diagnosed? 3a(iii): If tuberculosis, did she/he* receive treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, when, and how long?</i>
<b>3b.</b> a disease of the brain or a neurological disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes	3b(i). Explain:
<b>3c.</b> diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes	3c(i). For how many years? 3c(ii). Was it treated? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 3c(ii)a. How?
<b>3f.</b> an autoimmune disease, such as juvenile idiopathic arthritis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	3f(i). Explain:
<b>3g.</b> health problems related to toxic substances?	<input type="checkbox"/> No <input type="checkbox"/> Yes	3g(i). Explain:
<b>3i.</b> a birth defect or syndrome, or an infection identified at birth?	<input type="checkbox"/> No <input type="checkbox"/> Yes	3i(i). Explain:

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

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<b>6b.</b> cough?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6b(i). When? 6b(ii). Describe the cough and reasons.
<b>6c.</b> diarrhea?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6c(i). When? 6c(ii). Describe diarrhea and reasons.
<b>6d.</b> 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.
<b>6e.</b> weight loss?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6e(i). When? 6e(ii). Describe how much weight loss and reason(s).
<b>6f.</b> a rash?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6f(i). When? 6f(ii). Describe the rash and reasons.
<b>6g.</b> 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.
<b>6h.</b> night sweats?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6h(i). When? 6h(ii). Describe night sweats and reasons.
<b>6i.</b> severe headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes	6i(i). When? 6i(ii). Describe the severe headache and reasons.

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		<p>8e. Was the animal quarantined or tested?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>8e(i). Which one?</p> <p><i>If yes to tested,</i> 8e(ii). What was the result?</p>
<p><b>9.</b> Were you <b>EVER</b> told by a healthcare professional that she/he* had, or was suspected of having, a West Nile virus infection?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>9a. When was she/he* diagnosed?</p> <p><i>If this occurred within the past 4 months ask:</i> 9a(i). What was the name of the doctor/clinic?</p>
<p><b>10.</b> Did she/he* have any shots or immunizations, such as for the flu, COVID-19, MMR, chickenpox, rotavirus, etc.?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>10a. When was the last time?</p> <p>10b. What kind was it?</p> <p><i>If smallpox/vaccinia is named, ask these questions:</i> 10b(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</p> <p><i>If yes,</i> 10b(i)a. When did these symptoms resolve?</p> <p>10b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>?</p> <p>10b(ii)a. When?</p>
<p><b>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."</b></p>		
<p><b>11.</b> Did she/he* <b>EVER</b> get a tattoo?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>11a. When?</p> <p><i>If in the past 12 months, ask these questions:</i> 11b. Were shared or non-sterile instruments, needles or ink used? <input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>11c. Was the procedure performed outside of the United States or Canada? <input type="checkbox"/>No <input type="checkbox"/>Yes</p>

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		<i>If yes,</i> 11c(i). Where?
<p><b>12.</b> Did she/he* <b>EVER</b> have acupuncture, ear or body piercing?</p>	<input type="checkbox"/> No  <input type="checkbox"/> Yes	<p>12a. When?</p> <p><i>If in the past 12 months, ask these questions:</i></p> <p>12b. Were shared or non-sterile instruments or needles used?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <p>12c. Was the procedure performed outside of the United States or Canada?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <p><i>If yes,</i> 12c(i). Where?</p>
<p><b>13a.</b> Did she/he* <b>EVER</b> live with, or was she/he* cared for by, a person who has hepatitis?</p>	<input type="checkbox"/> No  <input type="checkbox"/> Yes	<p>13a(i). Describe what happened and when.</p> <p><i>If in the past 12 months, ask these questions:</i></p> <p>13a(ii). What type of hepatitis did <b>that person</b> have?</p> <p>13a(iii). 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><b>13b.</b> Did she/he* <b>EVER</b> live with, was she/he* cared for by, or did she/he* come in contact with a person who has tuberculosis?</p>	<input type="checkbox"/> No  <input type="checkbox"/> Yes	<p>13b(i). Describe the circumstances and when.</p>
<p><b>14.</b> Did she/he* <b>EVER</b> come into contact with someone else's blood?</p>	<input type="checkbox"/> No  <input type="checkbox"/> Yes	<p>14a. Describe what happened and when:</p> <p>14b. 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><b>15.</b> Did she/he* <b>EVER</b> have an accidental needle-stick?</p>	<input type="checkbox"/> No  <input type="checkbox"/> Yes	<p>15a. Describe what happened and when:</p>

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		<p>15b. 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>
<p><b>16.</b> Was she/he* <b>EVER</b> given or did she/he* use drugs, such as steroids, cocaine, heroin, amphetamines, or anything <b>NOT</b> prescribed by her/his* doctor?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<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><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If no,</i> 16d(i). How was it taken?</p>
<p><b>17.</b> Did she/he* <b>EVER</b> have any kind of surgery?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>17a. What kind?</p> <p>17b. Where?</p> <p>17c. When?</p>
<p><b>18.</b> Did she/he* <b>EVER</b> travel or live outside of the United States or Canada?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>18a. Where?</p> <p>18b. When and for how long?</p> <p>18c. Did she/he* <b>EVER</b> receive a blood transfusion or other medical treatment outside of the United States or Canada?</p> <p><input type="checkbox"/>No  <input type="checkbox"/>Yes <i>If yes,</i>  18c(i). What occurred (which one)?</p>

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		<p>18c(ii). Describe where and when:</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 #10.</i></p>
<p><b>19a.</b> Did she/he* <b>EVER</b> have a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?</p> <p><b>19b.</b> Did she/he* live with a person who had?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>19a(i). Explain:</p> <p>19b(i). Who was it?</p>
<p><b>20.</b> Did she/he* <b>EVER</b> have a positive or reactive test for:</p> <p style="padding-left: 40px;"><b>20a.</b> tuberculosis, such as a positive skin or blood test?</p> <p style="padding-left: 40px;"><b>20b.</b> the HIV/AIDS virus?</p> <p style="padding-left: 40px;"><b>20c.</b> hepatitis?</p> <p style="padding-left: 40px;"><b>20d.</b> HTLV-I or HTLV-II?</p> <p style="padding-left: 40px;"><b>20e.</b> <i>T. cruzi</i> or told she/he* has Chagas' disease?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>20a(i). What test was positive and when?</p> <p>20a(ii). Did she/he* receive treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><i>If yes, when, and how long?</i></p> <p>20b(i). Explain:</p> <p>20c(i). Explain:</p> <p>20d(i). Explain:</p> <p>20e(i). Explain:</p>
<p><b>21.</b> Did she/he* <b>EVER</b> have liver disease or hepatitis?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>21a. What kind?</p> <p>21b. When?</p>

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<b>23.</b> Was she/he* <b>EVER</b> told by a healthcare professional she/he* was infected with the Ebola Virus?	<input type="checkbox"/> No  <input type="checkbox"/> Yes	23a. When was she/he* diagnosed?
<b>24.</b> Did she/he* <b>EVER</b> have cancer?	<input type="checkbox"/> No  <input type="checkbox"/> Yes	24a. What type?  <i>If skin cancer:</i> 24a(i). What kind?  24b. When was it diagnosed?  24c. Describe when and where surgery, radiation, or chemotherapy occurred:  24d. Was the cancer considered cured? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 24d(i). When?
<b>25.</b> Did she/he* <b>EVER</b> have any eye problems, procedures, or surgery?	<input type="checkbox"/> No  <input type="checkbox"/> Yes	<i>If yes to eye problems:</i> 25a. What kind of eye problems?  <i>If yes to eye surgery or procedures:</i> 25b. What kind of surgery or procedure was performed and why?  25c. Which eye(s)? <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> unknown  25d. What is the name and/or phone number of her/his* eye doctor or eye clinic?
<b>26.</b> Did she/he* or <b>any</b> of her/his* relatives have Creutzfeldt-Jakob disease, which is also called CJD or variant CJD?	<input type="checkbox"/> No  <input type="checkbox"/> Yes	26a. Who did?  <i>If a relative,</i> 26a(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> 26a(ii). Which blood relative?

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		26b. Is there a physician, relative, or other person who can provide more information? ( <i>document discussion</i> )
27a. Did she/he* <b>EVER</b> live in a homeless shelter?	<input type="checkbox"/> No <input type="checkbox"/> Yes	27a(i). When?  27a(ii). Describe the situation  27a(iii). How long?
<b>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. For the next part, a sexual act refers to any method of sexual contact including vaginal, anal, and oral.</b>		
28. Did she/he* <b>EVER</b> have an infection such as syphilis, gonorrhea, chlamydia, or genital ulcers, herpes, or genital warts?	<input type="checkbox"/> No <input type="checkbox"/> Yes	28a. What was it?  28b. How was it treated?  28c. How long ago?
29. Do you have any reason to believe that she/he* was <b>EVER</b> involved in a sexual act, or was sexually assaulted or abused?	<input type="checkbox"/> No <input type="checkbox"/> Yes	29a. How long ago?  29b. Was any sexual act in exchange for money or drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>The following questions are about any person with whom sexual contact occurred. I will read each question and you should answer to the best of your knowledge with a "Yes" or "No."</b> 29c. Was the person male or female? <input type="checkbox"/> Female <input type="checkbox"/> Male <i>If male,</i> 29c(i). Was this person known to have sex with another male? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 27c(ii). When were they known to have sex with another man?  29d. Were they a person who has had sex in exchange for money or drugs?

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		<p><input type="checkbox"/>No  <input type="checkbox"/>Yes  <i>If yes,</i>  27d(i). When were they known to have had sex in exchange for money or drugs?</p> <p>29e. Were they 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>  27e(i). When were they known to have used a needle to inject drugs not prescribed by their own doctor?</p> <p>29f. Were they a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV?  <input type="checkbox"/>No  <input type="checkbox"/>Yes  <i>If yes,</i>  29g(i) Which virus?</p> <p>29f(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>29g. Were they a person who received a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?  <input type="checkbox"/>No  <input type="checkbox"/>Yes</p> <p><i>Note to interviewer: Question 29i., the HIV-1 Group O Risk Question, must be asked if the test kit being used for HIV-1 <b>Ab</b> testing is not labeled to include HIV-1 Group O. Check here if question 29i. was skipped. <input type="checkbox"/></i></p> <p>29h. Were they a person who was born in or lived in any country in Africa?  <input type="checkbox"/>No  <input type="checkbox"/>Yes  <i>If yes,</i>  29i(h). What country were they from?</p>
<p><b>30.</b> <i>If donor's age is 6 to 12 years (inclusive), ask: Was she/he* <b>EVER</b> in lockup, jail, prison, or any juvenile correctional facility?</i></p>	<p><input type="checkbox"/>N/A  <input type="checkbox"/>No  <input type="checkbox"/>Yes</p>	<p><i>(donor's age is &lt;6 years)</i></p> <p>30a. When?</p> <p>30b. How long?</p> <p>30c. Where?</p>

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