Donor Number (Completed by MMUH)		**IRD Number** (Completed by MMUH)			
Date					
Name & Title of Person Taking History					
Donor Coordinator Responsible					
Donor – Baby Name					
Donor - Mother Name					
Date of Birth of Baby					
Sex of Baby	**Male**		**Female**		
Donor Hospital					
Cause of Death – Main Diagnosis (Baby)					
1.					
2.					
3.					

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 / tissue 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".

Thank you for your time and willingness to complete this questionaire which is required by Irish and European law to make donated tissues and organs safer.

PART 1 – MEDICAL HISTORY – OF NEONATAL DONOR

1. History of high blood pressure	Yes		No		Unknown	
2. Previous spinal or neurological surgery?	Yes		No		Unknown	
3. Previous abdominal or chest surgery?	Yes		No		Unknown	
4. Any history of blood/blood products transfusion?	Yes		No		Unknown	
5. History of kidney disease?	Yes		No		Unknown	

6. History of heart disease?	Yes		No		Unknown	
7. History of liver disease?	Yes		No		Unknown	
8. History of disease or infection of heart valves?	Yes		No		Unknown	
9. History of respiratory disease?	Yes		No		Unknown	
10. History of cancer?	Yes		No		Unknown	
11. Any history of neurological disease of unknown cause?	Yes		No		Unknown	
12. Any current significant infection?	Yes		No		Unknown	
13. 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		Unknown	

F YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS PLEASE PROVIDE MORE INFORMATION / DETAIL ON PAGE FIVE OF THE QUESTIONNAIRE

PART 2 – MEDICAL HISTORY – MOTHER OF NEONATAL DONOR

1. History of high blood pressure	Yes		No		Unknown	
2. History of diabetes mellitus	Yes		No		Unknown	
3. History of smoking?	Yes		No		Unknown	
If yes Cigs / day						
4. History of alcohol?	Yes		No		Unknown	
If yes Units / week						
5. Previous spinal or neurological surgery?	Yes		No		Unknown	
6. Previous abdominal or chest surgery?	Yes		No		Unknown	
7. Any surgery in the UK since 1980?	Yes		No		Unknown	
8. Any history of blood/blood products transfusion?	Yes		No		Unknown	
9. Any history of haemophilia or related disease which required transfusion with coagulation factors?	Yes		No		Unknown	

10. Any history of ingesting or exposure to a substance such as gold, cyanide lead and mercury	Yes		No		Unknown		
11. 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		Unknown		
12. History of kidney disease?	Yes		No		Unknown		
13. History of heart disease (e.g. cardiomyopathy)	Yes		No		Unknown		
14. History of liver disease?	Yes		No		Unknown		
15. History of disease or infection of heart valves?	Yes		No		Unknown		
16. History of respiratory disease?	Yes		No		Unknown		
17. Previous history of cancer?	Yes		No		Unknown		
18.Any long-term treatments?	Yes		No		Unknown		
19. Any history of Creutzfeldt-Jakob disease in the patient or in the family?	Yes		No		Unknown		
20. Any history of dementia or neurological disease of unknown cause?	Yes		No		Unknown		
21. 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		Unknown		
22. History of vaccinations apart from usual childhood ones?	Yes		No		Unknown		
23. Has the donor currently any significant infection (e.g. septicaemia, viral disease, syphilis, active tuberculosis, systemic fungal disease, malaria, Chagas disease)?	Yes		No		Unknown		
24. 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		Unknown		
IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS PLEASE PROVIDE MORE INFORMATION / DETAIL ON PAGE FIVE OF THE QUESTIONNAIRE							

PART 3 – SOCIAL HISTORY OF MOTHER OF NEONATAL DONOR

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

1. Did you travel outside Ireland in the last year?	Yes		No		Unknown	
2. Did you ever live or work outside the Republic of Ireland?	Yes		No		Unknown	
3. Did you receive any tattoos, body-piercing or acupuncture during the last year?	Yes		No		Unknown	
4. Did you ever spend time in prison?	Yes		No		Unknown	
5. Did you ever inject any illegal drugs by injection or by any other route?	Yes		No		Unknown	
6. Did you have sexual relations with more than one partner in the last 12 months?	Yes		No		Unknown	
7. Did you ever have sex in order to obtain money or drugs?	Yes		No		Unknown	
8. Is it possible you ever had sexual relations with partners known to have AIDS or hepatitis?	Yes		No		Unknown	
9. Have you been treated for syphilis or gonorrhoea in the last 12 months?	Yes		No		Unknown	
IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS PLEASE PROVIDE MORE INFORMATION / DETAIL ON PAGE FIVE OF THE QUESTIONNAIRE						

Please complete this section if you answered Yes to any of the above questions.	
Question Number	
Person Interviewed	
Relationship to the deceased	
Signed (interviewee)	
Signed (interviewer):	
Title	
Signed	
Time and Date	