Non-Transplant Donor Health History

(MUST BE COMPLETED AT DONOR'S MEDICAL)

ANTHONY NOLAN
Saving lives through stem cells

Donor ID: an_gridformatted **Date:** 17/04/2024

Donor Name: fullname

1	What is your current living situation? Do you live by yourself or with other people? …… ……		
2	Are you currently employed or studying? ……	Yes ☐	No ☐
3	Do you have any allergies? If yes, please list: …… …… …… ……	Yes ☐ **Inform CLIENT if relevant**	No ☐
4	Have you had any immunisations / vaccinations in the last **four weeks**? Do you have plans to receive any before your donation? If yes, what/when?.....	Yes ☐ **Check vaccination type (e.g. live). Inform CLIENT, if live defer**	No ☐
5	Have you **ever** been pregnant (including miscarriages/terminations)? If yes, how many times?..... How many live births?.....	Yes ☐	No ☐
6	Is there any possibility you could be pregnant now? Date of beginning of last menstrual period……	Yes ☐	No ☐
7	Has any **first degree** relative (parent, sibling, child) been diagnosed with a blood cancer or any other blood disorder? If yes, please provide details …… ……	Yes ☐ **Inform CLIENT**	No ☐
8	Have you received a transfusion of blood, platelets or other blood product **since 1980**? If yes, when and where……..	Yes ☐ **Inform CLIENT**	No ☐
9	Are you a blood donor? If yes, when was the last time you donated blood?……	Yes ☐	No ☐
10	Have you **ever** had a bleeding problem, such as haemophilia or other clotting factor deficiencies and received blood products/clotting factor concentrates? If yes, please provide details ……	Yes ☐ **Defer**	No ☐
11	Have you **ever** been diagnosed with Creutzfeldt-Jakob-Disease (CJD), or do you have a degenerative neurological disease? If yes, please provide details ……	Yes ☐ **Defer**	No ☐
12	Has anyone in your family had CJD, or have you been told that your family has an increased risk for CJD? If yes, please provide details ……	Yes ☐ **Inform CLIENT**	No ☐
13	Have you had brain surgery or an operation for a tumour or cyst on the spine **prior** to August 1992?	Yes ☐	No ☐

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	If yes, please provide details ……	**Inform CLIENT**	
14	Have you **ever** received a corneal transplant, or had any other operations on your eyes? If yes, please provide details ……	Yes ☐ **Obtain details re: use of scleral/other ocular tissue grafts**	No ☐
15	Have you **ever** received a xenograft transplant (a surgical graft of tissue from one species to an unlike species)? If yes, please provide details ……	Yes ☐ **Defer**	No ☐
16	**Have you ever** been treated with human pituitary extracts such as growth hormones prior to 1985? If yes, please provide details ……..	Yes ☐ **Inform CLIENT**	No ☐
17	Have you **ever** had yellow jaundice, liver disease or hepatitis (except for jaundice as a young baby)? If yes, please provide details ……	Yes ☐ **Inform CLIENT**	No ☐
18	Have you ever suffered from a head injury? **If no go to Q19 (next question)**. If yes, please provide details of when and what type …… Have you suffered from more than 3 concussions in your lifetime? If yes, were there more than 6? …… Did you lose consciousness for more than 5 minutes? If yes, was it more than 1 hour?..... Post injury have you suffered from any of the following symptoms that lasted more than 72 hours: **short term memory loss, blurred vision, light or noise sensitivity, nausea or vomiting, dizziness or balance problems, difficulty thinking, poor concentration, seizure, personality changes, severe headache?** If yes, please provide more details…… ……	Yes ☐ Yes ☐ Yes ☐ Yes ☐	No ☐ No ☐ No ☐ No ☐
19	Are you or have you been in any type of therapy? This can include physiotherapy, cognitive behavioural therapy, counselling therapy eClient. If so, what type and when? ..... ……	Yes ☐	No ☐
20	Do you, or have you ever suffered from a mental health condition or disorder in relation to:		
a	Anxiety (including panic disorder, obsessive compulsive disorder- OCD and post-traumatic stress disorder- PTSD)?	Yes ☐	No ☐
b	Eating (including anorexia and bulimia nervosa)?	Yes ☐	No ☐

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c	Mood (including depression and bipolar disorder)?	Yes ☐	No ☐
d	Personality (including borderline personality disorder)?	Yes ☐	No ☐
e	Substance abuse? If yes, please specify:.....	Yes ☐	No ☐
f	Schizophrenia and other Psychotic Disorders (including schizoaffective and delusional disorder)	Yes ☐	No ☐
21	Are there any issues in your life that have required extra attention in the past 12 months? If yes, do you mind providing some detail about it? …….. …….. …….. …….. ……..	Yes ☐	No ☐
22	Have you travelled outside the UK and Ireland **in the last 12 months**? Please give all destinations with month and year of travel below …… …… …… …… …… …… …… …… …… …… …… **NOTES FOR ASSESSING CLINICIAN** For endemic areas and high-risk season for each country visited refer to geographical disease risk index (www.transfusionguidelines.org). If testing is required but results cannot be obtained in time donor can proceed at CLIENT's discretion. **Malaria** All visitors to endemic areas within the last 12 months should be tested, regardless of prophylaxis.	Yes ☐	No ☐

Status		**Action**
Visitor	<4 months since return	Request MAT **and NAT**
	4-12 months since return	Request MAT
	>12 months since return	Accept, No test
Resident Lived in a malaria area > 6 continuous months at any point in their life	<4 months since last exposure	**Request MAT and NAT**
	>4 months since last exposure	Request MAT
UFI Unexplained febrile illness	<4 months since last exposure	**Request MAT and NAT**
	>4 months since last exposure	Request MAT
History of Malaria	**<4 months** since recovery	**Request MAT and NAT**
	>4 months since recovery	**Request MAT**

West Nile Virus

Accept without testing:

- Visitors to endemic areas outside of high-risk season

- Visitors to endemic areas during high risk season who returned to the UK over 28 days ago and had neither symptoms nor evidence of WNV infection while abroad or since return

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	WNV NAT <u>should</u> be tested in the following instances: *- Visitors to endemic areas during high risk season (See Geographical Disease Risk Index) who have returned to the UK in last 28 days* *- Visitors to endemic areas during high risk season (See Geographical Disease Risk Index) who have returned to the UK within last six months and had symptoms suggestive of WNV while abroad or within 28 days of return* **<u>Tropical Viruses - Dengue Virus, Chikungunya, Zika Virus</u>** Accept <u>without</u> testing: *- Visitors to endemic areas who have returned to the UK over 28 days ago and had neither symptoms nor evidence suggestive of Chikungunya, Dengue or Zika virus infection while abroad or since return* NAT <u>should</u> be tested in the following instances: *- Visitors to endemic areas who have returned to the UK in last 28 days* *- Visitors to endemic areas who have returned to the UK within last six months and had symptoms or evidence of Dengue, Chikungunya or Zika virus infection while abroad or within 28 days of return* **<u>T. Cruzi (American Trypanosomiasis / Chagas' Disease See</u>** Qs 29-31		
23	Do you have plans to travel outside the UK and Ireland **between now and your donation date**? **If yes, where and when?**	Yes ☐ **Consult Geographical Disease Risk Index**	No ☐
24	Have you **ever** been diagnosed with West Nile Virus? If yes, when	Yes ☐ **Test WNV NAT if within last four months. Inform CLIENT**	No ☐

	Zika Virus Q25 - Please notify Anthony Nolan if donor answers yes to this question. Additional testing not required.		
25	Have you had sex with a male partner who had travelled or lived in a Zika virus affected area during the 3 months previous to sex? (*If you are unsure about regions affected by Zika Virus please discuss with the doctor / nurse during your medical assessment)* If yes, was the date of sex within the last 28 days?	Yes ☐ Yes ☐	No ☐ No ☐
26	Have you **ever** had malaria, or suffered an unexplained fever during or after visiting a malaria risk area? If yes, when/where ……	Yes ☐ **Test malaria anti-bodies. Inform CLIENT**	No ☐
27	Have you lived in a malaria risk area for six or more continuous months at any time of your life? If yes, when/where ……	Yes ☐ **Test malaria anti-bodies. Inform CLIENT**	No ☐
28	Were you born, or have you ever lived, in Africa? If yes, where?……..	Yes ☐ **Inform CLIENT**	No ☐
	T. Cruzi (American Trypanosomiasis / Chagas' Disease) Qs 30-32 All donors answering yes to any of these questions must have a T Cruzi antibody test performed. Donors who have travelled to these areas who do not answer yes to these questions <u>do not</u> need to be tested		
29	Have you **ever** been diagnosed with South American Trypanosomiasis (Chagas) disease? If yes, please provide details ……..	Yes ☐	No ☐
30	Were you or your mother born in South America or Central America (including Mexico, excluding Cuba)? If yes, please provide details ……..	Yes ☐	No ☐

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31	Have you lived and/or worked in rural farming communities in South America or Central America (including Mexico, excluding Cuba) for a continuous period of four weeks or more? If yes, please provide details ……	Yes ☐	No ☐
32 a	Have you ever been diagnosed with Viral Haemorrhagic Fever (VHF), including Crimean-Congo Fever, Ebola, Lassa Fever, Marburg fever? If yes, please provide details ……	Yes ☐ **Defer**	No ☐
b	Have you ever travelled to a VHF endemic area? e.g. Guinea, Liberia, Sierra Leone, Nigeria, eClient. If yes, please provide details ……	Yes ☐ **Defer if in area during active outbreak, if not defer for six months post return**	No ☐
c	Have you ever had a sexual partner diagnosed with VHF at any time before your last sexual contact? If yes, please provide details ……	Yes ☐ **Defer if partner diagnosed before last contact**	No ☐
33	Have you had sex (oral, vaginal or anal) with a new partner, or more than one partner, in the last 14 days?	Yes ☐	No ☐
34	In the past **three months** have you had sex (oral, vaginal or anal) with:		
a	A new partner, or more than one partner? If yes, did you have anal sex?	Yes ☐ Yes ☐ **Inform CLIENT**	No ☐ No ☐
b	an individual who is HIV positive or who has ever had syphilis, hepatitis B or C or yellow jaundice?	Yes ☐ **Inform CLIENT**	No ☐
c	anyone who has ever injected drugs?	Yes ☐ **Inform CLIENT**	No ☐
d	an individual who has ever been given or taken money in exchange for drugs or sex?	Yes ☐ **Inform CLIENT**	No ☐
35	Have you had chem sex or used drugs during sex (excluding erectile dysfunction drugs or cannabis) within the last **three months**?	Yes ☐ **Inform CLIENT**	No ☐
36	Have you given or taken money in exchange for drugs or sex within the last **three months**? If yes, please provide details …… …… ……	Yes ☐ **Inform CLIENT, consider deferral**	No ☐
37	Have you ever taken **PrEP** (Pre-Exposure Prophylaxis, anti-HIV medication)? If so was it in the **last 3 months**?	Yes ☐ Yes ☐	No ☐ No ☐

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		Defer	
38	Are you HIV positive, have you **ever** tested positive for HIV or do you think you may be HIV positive? If yes, please provide details ……	Yes ☐ **Defer**	No ☐
39	Have you **ever** had hepatitis B or C, have you **ever** tested positive for hepatitis B or C, or do you think you may have hepatitis now? If yes, please provide details ……	Yes ☐ **Defer**	No ☐
40	Have you **ever** tested positive for HTLV (Human T-lymphotropic virus)? If yes, when ……	Yes ☐ **Inform CLIENT**	No ☐
41	Within the last **four months** have you had an injury which could have put you at risk of hepatitis or HIV – for example a needle stick injury, coming into contact with someone else's blood through an open wound, non-intact skin, or mucous membrane (e.g. into your eye or mouth) If yes, please provide details …… ……	Yes ☐ **Inform CLIENT**	No ☐
42	**In the past 12 months** have you had a confirmed positive test result or been treated for syphilis or gonorrhoea? If yes, when ……..	Yes ☐ **Inform CLIENT**	No ☐
43	**Have you ever** injected or been injected with illegal or non-prescription drugs including bodybuilding drugs? If yes, please provide details …… …… ……	Yes ☐ **Inform CLIENT, consider deferral for 12 months**	No ☐
44	In the past **three months** have you undergone acupuncture in a **non-UK establishment or by an unqualified practitioner?** If yes, please provide details …… ……	Yes ☐ **Obtain professional reg certificate if possible. Inform CLIENT.**	No ☐
45	In the past **three months** have you had a tattoo (or tattoo removal), any piercing to your ears, face or body or undergone any cosmetic treatment that involved piercing the skin **in a non-licensed establishment**? If yes, please provide details …… ……	Yes ☐ **Inform CLIENT**	No ☐
46	In the past **four months** have you been detained in a prison for more than 72 continuous hours? If yes, please provide details …….. ……	Yes ☐ **Inform CLIENT**	No ☐
47	Have you **ever** been bitten by a non-human primate? e.g. ape, lemur If yes, please provide details ……	Yes ☐ **Defer**	No ☐
48	Have you been bitten by a bat in the last two years? If yes, please provide details ……	Yes ☐ **Defer for two**	No ☐

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		years from date of bite	
49	Have you ever been exposed to rabies? If yes, please provide details …… If yes, were you cleared by a Doctor/Physician? ……	Yes ☐ **Defer for two years from exposure date, if medically cleared.**	No ☐
50	**Have you ever** taken or been exposed to or ingested cyanide, lead or mercury? **Have you ever** ingested gold? If yes, please provide details …… ……	Yes ☐ Yes ☐ **Inform CLIENT**	No ☐ No ☐

Covid-19 screening			
51	In the past 14 days, have you had a confirmed or presumed diagnosis of COVID-19? If yes, when did you recover? ……... Has a negative test been confirmed? …….. If yes, when was this performed? ……..	Yes ☐ Yes ☐	No ☐ No ☐

Please provide next of kin details here:		
Name		an_gri
Relationship to you		an_do
Contact number		

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DONOR STATEMENT OF UNDERSTANDING

I have had the opportunity to ask questions about the information requested on the questionnaire "Donor Health History".

I understand that the requested information is important if I am at risk for infection due to HIV, Hepatitis B or C, or any other communicable disease agents or diseases, my donated cells may transmit these diseases to the recipient receiving the cells.

If at any time during the donation process I develop any of the following symptoms:
A cough, fever or difficulty breathing, I will contact my Donor Provision coordinator.

I have truthfully answered all the questions on this questionnaire.

I authorise the release of information on the questionnaire to the Cell and Gene Therapies Client. I understand that any information identifying me will remain confidential and only my unique donor identification number will be used on any information passed to the Cell and Gene Therapies Client.

I understand that authorising this release of information is voluntary and that I can refuse to sign this document.

Donor Details	
Name	fullname
GRID	an_gridformatted
Signature	

Reviewed by	
Name	
Signature	
Job Title	
Date	

If the donation date is 60 days or more since the original medical, please complete the following:

☐ I confirm there have been no changes to the above information provided, and I have advised the Collection Centre/AN of all health changes (if any) since my original medical

Donor name	
Signature*	
Date	

* If you are completing online and unable to insert a signature please just initial this box.