Femoral Head Donation Medical History & Consent

OFFICE USE

BB NUMBER

Title: *Please tick* ☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr ☐*Other* ……..	Surname:
Given Name/s:	Previous Surname:
Address:	
	Post Code:
Date of Birth:	Home Phone:
Work Phone:	Mobile:
Email Address:	

- If you have difficulty completing this consent form or have any questions regarding bone donation, please contact the Donor Liaison Nurse at PlusLife during business hours on **(08) 6144 3500** or email **donor.liaison@pluslife.org.au**
- Answer each question by marking the appropriate box next to each question using **an ink pen**.
- 'YES' answers will not automatically exclude you from donation. **Please provide extra information in the space provided.**
- Some questions are very personal, but all care is taken to respect your privacy. Information given is strictly confidential and will not be shared with a third party.

		Mark YES or NO	
1	Have you been diagnosed with cancer and / or received treatment for cancer? If 'YES' please give details:	☐ YES	☐ NO
2	Have you had any skin lesions removed (benign or malignant)? If 'YES' please give details:	☐ YES	☐ NO
3	Females only: In the past 5 years, have you had an abnormal Cervical Screening Test? If 'YES' please give details:	☐ YES	☐ NO
4	Have you lived in or visited England, Scotland, Wales, N. Ireland or Isle of Man for a cumulative/total period of more than 6 months between 1st January 1980 and 31st December 1996? If 'YES' please give details:	☐ YES	☐ NO
5	Have you migrated to Australia or lived outside of Australia? If 'YES' please list country and dates:	☐ YES	☐ NO
6	Have you received treatment for a skin condition (which may include Psoriasis, Pemphigus, Vitiligo)? If 'YES' please give details:	☐ YES	☐ NO
7	Have you received treatment for an Autoimmune Disease (which may include Type 1 Diabetes, Rheumatoid Arthritis, Crohn's, Ulcerative Colitis)? If 'YES' please give details:	☐ YES	☐ NO
8	Do you have a history of Osteomyelitis, Osteoporosis, Paget's Disease or Ankylosing Spondylitis? If 'YES' please give details:	☐ YES	☐ NO

		Mark YES or NO	
9	Have you taken or are you taking medication (including natural remedies) on a regular basis? If 'YES' please list: …….. …….. ……..	☐ YES	☐ NO
10	Have you had any serious illnesses? If 'YES' please list illness and date: …….. ……..	☐ YES	☐ NO
11	Have you previously been hospitalised or undergone <u>any</u> surgical procedure including day surgery e.g. gastroscopy, colonoscopy? If 'YES' please list reason, date, hospital & doctor: …… …… …… ……	☐ YES	☐ NO
12	Have you received a transplant of human tissue (including bone or dura), animal tissue, organ, cornea, donated sperm/egg or human pituitary derived growth hormone? If 'YES' please list reason, date, hospital and doctor:	☐ YES	☐ NO
13	Have you donated bone in the past? If 'YES' please list date:	☐ YES	☐ NO
14	Have you received a blood transfusion or blood products after <u>1980</u>? If 'YES' please list country received and date:	☐ YES	☐ NO
15	Have you been advised not to donate blood? If 'YES' please list reason:	☐ YES	☐ NO
16	Have you been diagnosed with a neurological condition, brain disease or seizures (e.g. Dementia, Alzheimer's, Meningitis, Multiple Sclerosis, Myasthenia Gravis, Parkinson's Disease)? If 'YES' please give details:	☐ YES	☐ NO
17	Have you been diagnosed with, or do you have a family history of Creutzfeldt-Jacob Disease (CJD)? If 'YES' please give details:	☐ YES	☐ NO
18	Have you been diagnosed with a lung condition (which may include Asthma, Tuberculosis)? If 'YES' please give details:	☐ YES	☐ NO
19	In the past <u>12 months</u>, have you taken steroid medication? If 'YES' please list reason & date:	☐ YES	☐ NO
20	In the past <u>12 months</u>, have you been vaccinated/immunised? If 'YES' please list type & date:	☐ YES	☐ NO
21	Within the past <u>12 months</u>, have you travelled within and / or outside of Australia? If 'YES' please identify place and date:	☐ YES	☐ NO

Donor Name: _____ **Date of Birth:** _____

Mark YES or NO

22	Have you had Typhus, Ross River Virus or Q Fever? If 'YES' please list date:	☐ YES	☐ NO
23	In the past 6 months, have you had an unexplained fever, illness with swollen glands or a rash with or without a fever? If 'YES' please give details:	☐ YES	☐ NO
24	Do you have a current infection? 'If 'YES' what is it and are you having treatment?	☐ YES	☐ NO
25	Have you received treatment for chemical or radiation exposure? If 'YES' please give details:	☐ YES	☐ NO
26	In the past 5 years, have you used illicit, non-prescription drugs/inhalants or injected even once, including cosmetic injections not under the supervision or direction of a medical practitioner? If 'YES' please give details:	☐ YES	☐ NO
27	Have you had Hepatitis A/Yellow Jaundice or tested positive for Hepatitis B, Hepatitis C, HIV (AIDS), Syphilis or HTLV? If 'YES' please list type and date:	☐ YES	☐ NO
28	In the past 12 months, have you been in close contact with someone who would answer 'YES' to questions 26 or 27? If 'YES' please give details:	☐ YES	☐ NO
29	In the past 6 months, have you had a tattoo, skin piercing or acupuncture? If 'YES' please list practice name, address and date:	☐ YES	☐ NO
30	In the past 6 months, have you been injured with a used needle (needle stick injury) or had a splash of blood or body fluids to your eyes, nose, mouth or to broken skin?	☐ YES	☐ NO
31	In the past 12 months, have you had a sexually transmitted disease (which may include Genital Herpes, Genital Warts, Chlamydia, Gonorrhoea)?	☐ YES	☐ NO
32	In the past 3 months, have you had sexual activity with a new partner who currently lives or recently lived overseas?	☐ YES	☐ NO
33	In the past 3 months, have you had sexual activity with a male who you think may be bisexual or had male to male sex?	☐ YES	☐ NO
34	In the past 3 months, have you been a sex worker or engaged in sexual activity with a sex worker?	☐ YES	☐ NO
35	In the past 12 months, have you been confined to a prison or detention centre?	☐ YES	☐ NO
36	In the past 3 months, have you engaged in sexual activity with someone who you think would answer 'YES' to questions 33 - 35?	☐ YES	☐ NO

Additional information:

_____

_____

_____

GP Name:	
Practice Name:	
Address:	
Phone:	**Fax:**

To authorise consent, please complete details on page 4.

Giving false or misleading information may incur penalties including fines and/or imprisonment.
If you do not wish to proceed with your donation, you need only decline. No questions will be asked.

Donor Name: _____ **Date of Birth:** _____

Surgeon:	Hospital:	Surgery Date:

Donor Declaration and Consent:

By ticking 'YES' I acknowledge; - I am freely consenting to retrieval of my femoral head and collection of the required blood and bone specimens at the time of my Total Hip Replacement surgery. - I give permission for the required pathology tests to be conducted, including blood screening for infectious diseases. If it is required, I consent to undergo a repeat blood test 6 months after surgery. - As scientific knowledge advances, I may be asked to undergo further blood tests. - My donation is a gift which is intended for surgical implantation. - I will not receive payment for my donation, nor will any costs be incurred by me. - I authorise my GP/Specialist, pathology service and hospital medical records department to release any relevant medical history to PlusLife. - I authorise PlusLife to collect and securely store information concerning this donation, including test results, medical history, reports and copies of medical records. - I authorise PlusLife to discuss information concerning this donation, including test results, medical history, reports and copies of medical records with other medical professionals as required. - I have been given sufficient information to understand the donation process and I have answered all questions truthfully.	☐ YES
If my donation is not suitable for transplant, I consent for it to be used for research and training purposes related to the production and implantation of tissue grafts.	☐ YES ☐ NO Office use:

Donor Name:	Signature:	Date:

PlusLife Office Use:

Interim Consent Completed (tick if applicable) ☐	**Verbal Consent Obtained** (tick if applicable) ☐
RECORD OF DONOR INTERVIEW: I have confirmed the identity of the Donor and confirmed that the Donor has answered the questions and provided consent. I have interviewed the Donor and reviewed the information provided by the Donor herein.	**Interviewer Name:** **Signature:** **Date:**

RECORD OF DONOR FACE-TO-FACE ASSESSMENT:

Interviewer has confirmed the identity of the donor and completed the face-to-face assessment.
Both the Donor and Interviewer have confirmed the information on the form is correct and complete, including any additions made by the interviewer during the donor interview/completion of the interim consent.

Donor Name:	Interviewer Name:
Signature:	Signature:
Date:	Date:

Apply Addressograph