DukeMedicine
Division of Cellular Therapy

ADULT AND PEDIATRIC BLOOD AND MARROW TRANSPLANT PROGRAM

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DOCUMENT TITLE:
Interim Donor History Questionnaire FRM4

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APBMT-COMM-001 FRM4
INTERIM DONOR HISTORY QUESTIONNAIRE

Place Patient ID Label

☐ Male ☐ Female ☐ ABMT ☐ PBMT

HISTORY QUESTIONS (Ask each collection day)									
Product Number (Bar Code Label)	Date:			Date:			Date:		
Questions:	**Y**	**N**	**Remarks**	**Y**	**N**	**Remarks**	**Y**	**N**	**Remarks**
1. In the last 24 hours have you had flu-like symptoms, such as fever, chills, nausea, vomiting, diarrhea, body aches, sore throat, or headache?	Y	N		Y	N		Y	N	
2. Do you have a cough, trouble breathing, or chest pain?	Y	N		Y	N		Y	N	
3. Have you taken any medications?	Y	N	☐ Refer to Medication Reconciliation	Y	N	☐ Refer to Medication Reconciliation	Y	N	☐ Refer to Medication Reconciliation
4. Have you read the information sheet provided: "Important Information Donors Must Know about Stem Cell or Other Cellular Therapy Donations"?	Y	N/A	☐ (ABMT) Autologous Donors. ☐ (PBMT) < 16 years of age.	Y	N/A	☐ (ABMT) Autologous Donors. ☐ (PBMT) < 16 years of age	Y	N/A	☐ (ABMT) Autologous Donors. ☐ (PBMT) < 16 years of age
5. **Allogeneic donors**: Has there been any change in your health history or risk factors since your last medical evaluation?	Y	N	☐ N/A	Y	N	☐ N/A	Y	N	☐ N/A
6. **Autologous donors**: Has there been any change in your health status since your last medical evaluation?	Y	N	☐ N/A	Y	N	☐ N/A	Y	N	☐ N/A
7. When did you take your last growth factor?	Time:		☐ N/A	Time:		☐ N/A	Time:		☐ N/A
8. Do you have a history of reactions to blood products?	Y	N	☐ N/A	Y	N	☐ N/A	Y	N	☐ N/A
Staff Signature:									
Physician Signature:									

Instructions for Completing the Interim Donor History Questionnaire

The Interim Donor History Questionnaire will be completed for each Autologous and Allogeneic apheresis collection to assure patient and donor safety. Ask each question every day of collection. Circle "Y" for yes, "N" for no, "N/A" for not applicable. Record any information in "Remarks" column.

Name and History Number	Attach the Name and History # of the donor undergoing apheresis.
Sex	Check whether the patient is a MALE or FEMALE.
Program	Check whether the patient is an ABMT or PBMT patient.
Date	Record date of collection.
Product Number (Bar Code Label)	Place bar code label here each day of collection.
1. In the last 24 hours have you had flu-like symptoms, such as fever, chills, nausea, vomiting, diarrhea, body aches, sore throat, or headache?	Evaluating for acute illness, other than colony stimulating factors (CSF) aches and pains. Donors with flu symptoms should be evaluated by the physician or extender.
2. Do you have a cough, trouble breathing, or chest pain	Evaluating for any cardiac, respiratory, or infectious processes. Donors with any of these symptoms should be evaluated by the physician or extender.
3. Have you taken any medications?	List all medications taken within the last 24 hours. List all medications or check the box next to Refer to Medication Reconciliation which is located in the electronic medical record.
4. Have you read the information sheet provided: "Important Information Donors Must Know about Stem Cell or Other Cellular Therapy Donations to Patients"?	If donor is an ABMT autologous donor, or less than <16 years old, circle "**N/A**". Then check whether the patient is an (ABMT) autologous donor or less than < 16 years old. If donor is an ABMT allogeneic donor, or a PBMT donor >16 years old, verify that donor has received the information and then circle "**Y**".
5. **Allogeneic donors**: Has there been any change in your health history or risk factors since your last medical evaluation?	Evaluating for any new health problem, travel, or "at risk" behavior since completing the Adult Donor Health Questionnaire. Any change requires review and evaluation by physician. "**N/A**" for Autologous DONORs
6. **Autologous donors**: Has there been any change in your health status since your last medical evaluation?	Evaluating for new change in health status since last medical evaluation. Any change requires review and evaluation by physician. "**N/A**" for Allogeneic DONORS
7. When did you take your last growth factor?	Document time of last growth factor. If **NOT** given in the clinic document approximate time given.
8. Do you have a history of reactions to blood products?	"**N/A**" for Autologous and/or Allogeneic DONORs that do **NOT** require a blood prime using the Optia Apheresis System.
Staff Signature:	Apheresis staff member recording information signs here.
Physician Signature:	Clinic attending physician signs here after review.

Signature Manifest

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APBMT-COMM-001 FRM4 Interim Donor History Questionnaire

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