

You are being considered as a potential bone marrow donor

We wish to evaluate further whether you can be a donor for a specific patient, either with donating bone marrow or peripheral blood stem cells, or to donate other kinds of blood cells to the patient.

When a patient has a bone marrow transplant, the patient receives new blood-forming stem cells from the donor. This is why a bone marrow transplant is also called stem cell transplant, and a bone marrow donor is also called a stem cell donor.

We are now making plans for a health examination with the purpose to evaluate whether it is medically safe for you to donate bone marrow or stem cells, and whether there is any risk of transmission of infectious diseases to the patient.

When you are healthy, donating bone marrow or peripheral blood stem cells has very low risk. Because some health problems may increase the risk of complications, we ask a lot of questions concerning your health. Together with the health examination this information will help us in the evaluation of whether it is medically safe to ask you to donate bone marrow or stem cells.

Both blood and cells may transmit an infectious disease from a donor to a patient. You can be a carrier of transmissible infective agents without knowing. That is why all bone marrow donors are tested for infection disease markers. Even though these tests are highly reliable, a person with a normal blood sample may still be a carrier of an infectious disease at a given time. To evaluate if there is any risk of transmission of infectious diseases to the patient we ask a lot of questions concerning situations where you may have been exposed to infectious diseases.

Please note that some questions answered "yes" will not necessary exclude you from further consideration as a donor. Some questions are based on international standards and may have low significance for conditions in Norway.

If you agree to be evaluated as a donor, please fill in the enclosed self-health assessment questionnaire. The staff at The Norwegian Bone Marrow Donor Registry has professional secrecy. Information from the self-health assessment questionnaire will be of internal use in The Norwegian Bone Marrow Donor Registry. Some information relevant for the patient you are under consideration for, as for instance allergies, may be forwarded to the patient's physician after being made anonymous.

When answering "yes" to the question at the end of the self-health assessment questionnaire enclosed, you are agreeing to be evaluated for a donation. Even if you are agreeing to be evaluated, you can withdraw at any time – if you want to.

If you have doubts whether you can be a bone marrow donor, or you have other questions, please feel free to contact The Norwegian Bone Marrow Donor Registry at telephone +47-2307-3770 or email nordonor@ous-hf.no. You can also visit our website www.nbmdr.org for more information.

Best regards,

The Norwegian Bone Marrow Donor Registry

Self-Health assessment questionnaire – page 1. Please fill in:

Name:	Social security number:	For internal use:
Address:		
Zip code/City:	Phone:	
Employer:	Email:	

Please answer:		
Do you feel healthy now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever donated blood?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you take any medications on a regular base?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which?		
Have you ever had Covid-19 infection? If yes, when?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been vaccinated against Covid-19?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you during the last four weeks:		
- used any medications?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- been sick or had a fever?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had any vaccinations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you during the last twelve months:		
- had a medical check-up or been hospitalized, or been treated for any illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, for what?		
- had a venereal disease, or been treated for a venereal disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had a tattoo or piercing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- undergone acupuncture?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had a tick-bite?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- been outside Scandinavia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when and where?		
- been detained in a prison for more than 72 continuous hours?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had new sexual partner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had sexual contact with a person who has received blood or blood products?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had sexual contact with a person infected by HIV, hepatitis B or hepatitis C, or a person who has tested positive for any of these diseases?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had sexual contact with a person who are using or have been using narcotics or other illegal substances by injections or insufflation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had sexual contact with a sex worker or former sex worker?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had a needle stick or cut injury with items contaminated with blood or body fluids, or spilled blood on mucous membrane or non-intact skin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, has this been followed up? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Self-Health assessment questionnaire – page 2. Please fill in:

Have you during the last two years:		
- had rare or serious infections?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which and when?		
Have you at any time in life:		
- had heart-, liver- or pulmonary disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had a bleeding problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, for what?		
- had malaria?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had any tropical disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had syphilis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had hepatitis, HIV or AIDS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- tested positive for hepatitis or HIV?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had any other serious disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which and when?		
- been treated with growth hormones?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- had a cornea transplant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Been through surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- injected or insufflated narcotics or other illegal substances?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- received money or drugs in exchange for sex?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
- received a transfusion of blood or other blood products?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, how many times, where and when?		
For female donors only:		
Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been pregnant before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, how many times?		
Have you been pregnant during the last twelve months, or are you breastfeeding now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you plan to become pregnant within the next six months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you during the last twelve months had sexual contact with a man who, to your knowledge, has had sex with other men?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
For male donors only:		
Have you ever had sexual contact with other men?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Self-Health assessment questionnaire – page 3. Please fill in:

Please answer:			
- Have you or your sexual partner had a long stay outside Scandinavia, or been born abroad?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, where and when?			
In the past six months, have you or your sexual partner travelled to Zika risk areas (Brazil, Thailand ect.)?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, where and when?			
Have you during the last three years been in an area where there is malaria?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you stayed for a minimum of six continuous months in an area where there is malaria?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you or your mother born in America south of USA?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had an unexplained fever, which you could have picked up whilst travelling?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you used narcotics one or several times in the last twelve months?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you or anyone in your family been diagnosed with Creutzfeldt-Jakob disease or a variant of this?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been received smallpox vaccine within the last 4 months, or been in close contact with someone who has, in the same time period?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has anyone in your closest family (parents, siblings, children) been diagnosed with a haematological malignancy (leukemia/lymphoma)?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you, any members of your household or present or former sexual partners had a medical procedure that involved being exposed to live cells/tissues/organs from an animal (xenotransplant)? This does not include non-living products as heart valves from pig or insulin.		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you vaccinated against Hepatitis B?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you received Hepatitis B Immune Globulin?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weight:	kg	Height:	cm

Comments:**Statement:**

Please answer "yes" or "no"

I have read the information enclosed, and answered the questions to the best of my knowledge.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I understand that I am under evaluation for a specific patient, and I am willing to be further evaluated for a donation for this patient.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

City:	Date:	Signature:
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