

Your logo

Uniform Donor Risk Assessment Interview Child Donor ≤12 years old

Your address

Donor Name: _____
First Middle Last

Person Interviewed: _____
Name Relationship

Contact Information: (_____) _____
Phone Address City State Zip

The interview was conducted: by telephone in person

Person Interviewed: _____
Name Relationship

Contact Information: (_____) _____
Phone Address City State Zip

The interview was conducted: by telephone in person

Person conducting interview and completing this form:

Print Name Signature Date/Time

I want to advise you of the sensitive and personal nature of some of these questions. They are similar to those asked when someone donates blood. We ask these questions for the health of those who may receive her/his* gift of donation. I will read each question and you will need to answer to the best of your knowledge with a "Yes" or "No."

1. What was her/his* date of birth?

Date of Birth: _____

Interviewer calculates the donor's age: _____

- If ≤18 months old, complete the Uniform DRAI (Birth Mother) in addition to this form.
- If <5 years old, ask question 1a:

1a. Within the past 12 months, was she/he* breastfed or was she/he* fed breast milk from another person?

No

Yes

If yes, ask:

1a(i). Who provided the breast milk? _____

- If this is the birth mother, complete the Uniform DRAI (Birth Mother) in addition to this form.

Check which Uniform DRAI form(s) will be completed:

Uniform DRAI (Child Donor ≤12 years old)

Uniform DRAI (Birth Mother)

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<p>2. Where was she/he* born?</p>		
<p>3. Did she/he* have any illnesses or ongoing problems with health, such as:</p> <p>3a. lung disease such as asthma, cystic fibrosis, or tuberculosis?</p> <p>3b. a disease of the brain or a neurological disease?</p> <p>3c. diabetes?</p> <p>3d. high blood pressure?</p> <p>3e. heart problems or heart disease?</p> <p>3f. an autoimmune disease, such as juvenile idiopathic arthritis?</p> <p>3g. health problems related to toxic substances?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p><i>If any answer in question 3. is "yes," further questioning is required.</i></p> <p>3a(i). Explain:</p> <p>3a(ii): If tuberculosis, when was she/he* diagnosed?</p> <p>3a(iii): If tuberculosis, did she/he* receive treatment?</p> <p style="padding-left: 20px;"><input type="checkbox"/> No</p> <p style="padding-left: 20px;"><input type="checkbox"/> Yes</p> <p style="padding-left: 40px;"><i>If yes, when, and how long?</i></p> <p>3b(i). Explain:</p> <p>3c(i). For how many years?</p> <p>3c(ii). Was it treated?</p> <p style="padding-left: 20px;"><input type="checkbox"/> No</p> <p style="padding-left: 20px;"><input type="checkbox"/> Yes</p> <p style="padding-left: 40px;"><i>If yes,</i></p> <p style="padding-left: 40px;">3c(ii)a. How?</p> <p>3d(i). Explain:</p> <p>3d(ii). For how many years?</p> <p>3e(i). Explain:</p> <p>3e(ii). How was it treated?</p> <p>3f(i). Explain:</p> <p>3g(i). Explain:</p>

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<p>3h. kidney disease, frequent kidney infections, or was she/he* treated with dialysis?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>3h(i). Explain and include when:</p> <p>3h(ii). If treated with dialysis, was it peritoneal dialysis or hemodialysis?</p>
<p>3i. a birth defect or syndrome, or an infection identified at birth?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>3i(i). Explain:</p>
<p>4a. Did she/he* have a pediatrician, a family physician, or a specialist?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>4a(i). When was her/his* last visit?</p> <p>4a(ii). Why?</p> <p>4a(iii). Who do they see or where do they go? <i>Provide any contact information (e.g., name, group, facility, phone number, etc.):</i></p>
<p>4b. Did she/he* use a medical facility such as a clinic or urgent care center?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>4b(i). When was her/his* last visit?</p> <p>4b(ii). Why?</p> <p>4b(iii). Who do they see or where do they go? <i>Provide any contact information (e.g., name, group, facility, phone number, etc.):</i></p>
<p>5a. Did she/he* take any prescription medication recently or on a regular basis?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>5a(i). What was it and/or what was it used for?</p> <p><i>If a steroid, such as prednisone, ask:</i></p> <p>5a(ii) How long?</p> <p>5a(iii) What was the dose?</p>
<p>5b. Did she/he* take any non-prescribed medication or dietary supplements?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>5b(i). What was it and/or what was it used for?</p>

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<p>6. Did she/he* recently have any symptoms such as:</p>		<p><i>If any answer in question 6. is "yes," ask "when" this occurred <u>and</u> "describe symptoms and reasons," if known.</i></p>
<p>6a. a fever?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>6a(i). When?</p> <p>6a(ii). Describe the fever and reasons.</p>
<p>6b. cough?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>6b(i). When?</p> <p>6b(ii). Describe the cough and reasons.</p>
<p>6c. diarrhea?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>6c(i). When?</p> <p>6c(ii). Describe diarrhea and reasons.</p>
<p>6d. swollen lymph nodes or glands in the neck, armpits or groin?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>6d(i). When?</p> <p>6d(ii). Describe swollen lymph nodes or glands and reasons.</p>
<p>6e. weight loss?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>6e(i). When?</p> <p>6e(ii). Describe how much weight loss and reason(s).</p>
<p>6f. a rash?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>6f(i). When?</p> <p>6f(ii). Describe the rash and reasons.</p>
<p>6g. sores in the mouth or on the skin?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>6g(i). When?</p> <p>6g(ii). Describe the sores and reasons.</p>

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<p>6h. night sweats?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>6h(i). When?</p> <p>6h(ii). Describe night sweats and reasons.</p>
<p>6i. severe headache?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>6i(i). When?</p> <p>6i(ii). Describe the severe headache and reasons.</p>
<p>6j. rapid decline in <u>mental</u> functions, such as behaving differently than normal?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>6j(i). When?</p> <p>6j(ii). Describe rapid decline in mental functions and reasons.</p>
<p>6k. rapid decline in <u>physical</u> functions, such as moving differently than normal?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>6k(i). When?</p> <p>6k(ii). Describe decline in physical functions and reasons.</p>
<p>7. Did she/he* have contact with anyone who had a smallpox vaccination?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>7a. Was that person vaccinated within the past 2 months?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> <p>7a(i). Did she/he* have contact with this person which includes touching the vaccination site, handling bandages that cover it, or handling bedding, clothing, or any other material that came in contact with the vaccination site?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> <p>7a(i)a. Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> <p>7a(i)a(i). Explain:</p>
<p>8. Was she/he* EVER bitten or scratched by any pet, stray, farm, or wild animal?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>8a. What kind of animal?</p>

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		<p>8b. When?</p> <p>8c. Did she/he* receive any medical treatment? <input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i> 8c(i). By whom?</p> <p>8d. Was the animal suspected of having rabies? <input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>8e. Was the animal quarantined or tested? <input type="checkbox"/>No <input type="checkbox"/>Yes 8e(i). Which one? <i>If yes to tested,</i> 8e(ii). What was the result?</p>
<p>9. Were you EVER told by a healthcare professional that she/he* had, or was suspected of having, a West Nile virus infection?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>9a. When was she/he* diagnosed? <i>If this occurred within the past 4 months ask:</i> 9a(i). What was the name of the doctor/clinic?</p>
<p>10. Did she/he* have any shots or immunizations, such as for the flu, COVID-19, MMR, chickenpox, rotavirus, etc.?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>10a. When was the last time?</p> <p>10b. What kind was it? <i>If smallpox/vaccinia is named, ask these questions:</i> 10b(i). Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? <input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i> 10b(i)a. When did these symptoms resolve?</p> <p>10b(ii). Did the scab <u>fall off</u> or was it <u>picked off</u>? 10b(ii)a. When?</p>

**This is a reminder these are standard questions we ask in every interview.
 Answer to the best of your knowledge with a "Yes" or "No."**

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<p>11. Did she/he* EVER get a tattoo?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>11a. When?</p> <p><i>If in the past 12 months, ask these questions:</i></p> <p>11b. Were shared or non-sterile instruments, needles or ink used? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>11c. Was the procedure performed outside of the United States or Canada? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 11c(i). Where?</p>
<p>12. Did she/he* EVER have acupuncture, ear or body piercing?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>12a. When?</p> <p><i>If in the past 12 months, ask these questions:</i></p> <p>12b. Were shared or non-sterile instruments or needles used? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>12c. Was the procedure performed outside of the United States or Canada? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 12c(i). Where?</p>
<p>13a. Did she/he* EVER live with, or was she/he* cared for by, a person who has hepatitis?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>13a(i). Describe what happened and when.</p> <p><i>If in the past 12 months, ask these questions:</i></p> <p>13a(ii). What type of hepatitis did that person have?</p> <p>13a(iii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>13b. Did she/he* EVER live with, was she/he* cared for by, or did she/he* come in contact with a person who has tuberculosis?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>13b(i). Describe the circumstances and when.</p>
<p>14. Did she/he* EVER come into contact with someone else's blood?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>14a. Describe what happened and when:</p>

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		<p>14b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>
<p>15. Did she/he* EVER have an accidental needle-stick?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>15a. Describe what happened and when:</p> <p>15b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>
<p>16. Was she/he* EVER given or did she/he* use drugs, such as steroids, cocaine, heroin, amphetamines, or anything NOT prescribed by her/his* doctor?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>16a. What was it?</p> <p>16b. How often and how long was it used?</p> <p>16c. When was it last used?</p> <p>16d. Were needles used?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If no,</i> 16d(i). How was it taken?</p>
<p>17. Did she/he* EVER have any kind of surgery?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>17a. What kind?</p> <p>17b. Where?</p> <p>17c. When?</p>
<p>18. Did she/he* EVER travel or live outside of the United States or Canada?</p>	<p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p>18a. Where?</p> <p>18b. When and for how long?</p>

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		<p>18c. Did she/he* EVER receive a blood transfusion or other medical treatment outside of the United States or Canada?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <i>If yes,</i></p> <p>18c(i). What occurred (which one)?</p> <p>18c(ii). Describe where and when:</p> <p><i>If international travel or residency is extensive, be aware of query regarding vaccinations or other shots (within the past 12 months) at question #10.</i></p>
<p>19a. Did she/he* EVER have a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?</p> <p>19b. Did she/he* live with a person who had?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>19a(i). Explain:</p> <p>19b(i). Who was it?</p>
<p>20. Did she/he* EVER have a positive or reactive test for:</p> <p style="padding-left: 20px;">20a. tuberculosis, such as a positive skin or blood test?</p> <p style="padding-left: 20px;">20b. the HIV/AIDS virus?</p> <p style="padding-left: 20px;">20c. hepatitis?</p> <p style="padding-left: 20px;">20d. HTLV-I or HTLV-II?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>20a(i). What test was positive and when?</p> <p>20a(ii). Did she/he* receive treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><i>If yes, when, and how long?</i></p> <p>20b(i). Explain:</p> <p>20c(i). Explain:</p> <p>20d(i). Explain:</p>

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20e. <i>T. cruzi</i> or told she/he* has Chagas' disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes	20e(i). Explain:
21. Did she/he* EVER have liver disease or hepatitis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	21a. What kind? 21b. When?
22. Did she/he* EVER have malaria?	<input type="checkbox"/> No <input type="checkbox"/> Yes	22a. When? 22b. Where was she/he* treated?
23. Was she/he* EVER told by a healthcare professional she/he* was infected with the Ebola Virus?	<input type="checkbox"/> No <input type="checkbox"/> Yes	23a. When was she/he* diagnosed?
24. Did she/he* EVER have cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes	24a. What type? <i>If skin cancer:</i> 24a(i). What kind? 24b. When was it diagnosed? 24c. Describe when and where surgery, radiation, or chemotherapy occurred: 24d. Was the cancer considered cured? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 24d(i). When?
25. Did she/he* EVER have any eye problems, procedures, or surgery?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>If yes to eye problems:</i> 25a. What kind of eye problems? <i>If yes to eye surgery or procedures:</i> 25b. What kind of surgery or procedure was performed and why? 25c. Which eye(s)? <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> unknown

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		25d. What is the name and/or phone number of her/his* eye doctor or eye clinic?
26. Did she/he* or any of her/his* relatives have Creutzfeldt-Jakob disease, which is also called CJD or variant CJD?	<input type="checkbox"/> No <input type="checkbox"/> Yes	26a. Who did? <i>If a relative,</i> 26a(i). Is this person a blood relative? (<i>Note: The definition of blood relative is a person who is related through a common ancestor and not by marriage or adoption</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes,</i> 26a(ii). Which blood relative? 26b. Is there a physician, relative, or other person who can provide more information? (<i>document discussion</i>)
27a. Did she/he* EVER live in a homeless shelter?	<ul style="list-style-type: none"> • No • Yes 	27a(i). When? 27a(ii). Describe the situation 27a(iii). How long?
<p>As I described before, I want to remind you of the sensitive and personal nature of some of these questions. For medical and health reasons, we are required to ask these questions about all potential donors. For the next part, a sexual act refers to any method of sexual contact including vaginal, anal, and oral.</p>		
28. Did she/he* EVER have an infection such as syphilis, gonorrhea, chlamydia, or genital ulcers, herpes, or genital warts?	<input type="checkbox"/> No <input type="checkbox"/> Yes	28a. What was it? 28b. How was it treated? 28c. How long ago?
29. Do you have any reason to believe that she/he* was EVER involved in a sexual act, or was sexually assaulted or abused?	<input type="checkbox"/> No <input type="checkbox"/> Yes	29a. How long ago? 29b. Was any sexual act in exchange for money or drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes <p>The following questions are about any person with whom sexual contact occurred. I will read each question and</p>

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	<p>you should answer to the best of your knowledge with a "Yes" or "No."</p> <p>29c. Was the person male or female?</p> <p><input type="checkbox"/>Female <input type="checkbox"/>Male <i>If male,</i></p> <p>29c(i). Was this person known to have sex with another male?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i></p> <p>27c(ii). When were they known to have sex with another man?</p> <p>29d. Were they a person who has had sex in exchange for money or drugs?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i></p> <p>27d(i). When were they known to have had sex in exchange for money or drugs?</p> <p>29e. Were they a person who used a needle to inject drugs that were not prescribed by their own doctor?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i></p> <p>27e(i). When were they known to have used a needle to inject drugs not prescribed by their own doctor?</p> <p>29f. Were they a person who has received medication for a bleeding disorder such as hemophilia?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i></p> <p>27f(i). What was it and when was it used?</p> <p>29g. Were they a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes <i>If yes,</i></p> <p>29g(i) Which virus?</p> <p>29g(ii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>
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		<p>29h. Were they a person who received a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><i>Note to interviewer: Question 29i., the HIV-1 Group O Risk Question, must be asked if the test kit being used for HIV-1 Ab testing is not labeled to include HIV-1 Group O. Check here if question 29i. was skipped.</i> <input type="checkbox"/></p> <p>29i. Were they a person who was born in or lived in any country in Africa?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p><i>If yes,</i> 29i(i). What country were they from?</p>
<p>30. <i>If donor's age is 6 to 12 years (inclusive), ask: Was she/he* EVER in lockup, jail, prison, or any juvenile correctional facility?</i></p>	<p><input type="checkbox"/>N/A <input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p><i>(donor's age is <6 years)</i></p> <p>30a. When?</p> <p>30b. How long?</p> <p>30c. Where?</p> <p>30d. Why?</p>
<p>31. <i>If an organ donor, ask: Did she/he* have any allergies?</i></p>	<p><input type="checkbox"/>N/A <input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p><i>(not an organ donor)</i></p> <p>31a. What was she/he* allergic to?</p> <p>31b. Describe reaction:</p>
<p>32. <i>If an organ donor, ask: Did she/he* EVER smoke?</i></p>	<p><input type="checkbox"/>N/A <input type="checkbox"/>No <input type="checkbox"/>Yes</p>	<p><i>(not an organ donor)</i></p> <p>32a. What was it?</p> <p><i>If cigarettes:</i> 32a(i). How many packs per day?</p> <p>32b. How many years?</p> <p>32c. Did she/he* quit?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes</p>

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		<i>If yes, 32c(i). When?</i>
33. <i>If an organ donor, ask:</i> Did she/he* EVER drink alcohol?	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes	<i>(not an organ donor)</i> 33a. What type? 33b. How often? 33c. How much? 33d. How long?
34. <i>If an organ donor, ask:</i> 34a. Did her/his* family have a history of diabetes?	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes	<i>(not an organ donor)</i> 34a(i). Describe type of relative, such as mother, father, sister, brother, etc.:
34b. Did her/his* family have a history of coronary artery disease which is a buildup of plaque in the heart's arteries?	<input type="checkbox"/> No <input type="checkbox"/> Yes	34b(i). Describe type of relative, such as mother, father, sister, brother, etc.:
<i>Final Questions</i>		
35. Are there other medical conditions you are aware of that we have not discussed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	35a. Describe:
36. Do you now have any concerns that her/his* donation should not proceed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	36a. Can you share your concerns?
37. Regarding these questions, are there other people, including healthcare professionals, who may provide additional information?	<input type="checkbox"/> No <input type="checkbox"/> Yes	37a. Name(s) and contact information:
38. Do you have any questions about these questions?	<input type="checkbox"/> No <input type="checkbox"/> Yes	38a. Document:

* The interviewer should mix the appropriate pronoun with other terms with which the interviewee can relate: the donor's given name; their nickname; inserting son, daughter, or child (as indicated).

