

BEARS Brain Donor Questionnaire

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UC Davis MIND Institute

Brain Endowment for Autism Research Sciences (BEARS) Program

24-Hour Toll Free Phone: (855) 221-HOPE (4673)

Email: mindbears@ucdavis.edu

Fax: (916) 703-0483

The BEARS Tissue Program is committed to advancing research around the world to find the causes of, develop treatments, and ultimately prevention options for neurodevelopmental disorders. All information provided on this form, as well as all of the donor's medical records, will solely be used for research purposes and kept confidential by the MIND Institute BEARS Tissue Program. We request that you complete the questionnaire as fully as possible, and return to us preferably within two months. Thank you so much for your support and involvement with the BEARS Tissue Program.

Most Recent Address

Donor's City of Birth

Donor's State of Birth

Donor's Country of Birth

Donor's Gender

Father's Name

Mother's Name & Maiden Name

Supporting Documents

Please check any of the following documents that you can either send, fax or email to us.

- ☐ The donor's death certificate (if possible at this time)
- ☐ The donor's birth certificate
- ☐ Clinical records concerning the donor or his/her family's medical history

Information about the Person Completing this Form

Informant's Full Name

Informant's Address

City	<input type="text"/>
State	<input type="text"/>
Zip Code	<input type="text"/>
Telephone Number	<input type="text"/>
Additional Phone Number	<input type="text"/>
Informant's Relationship to Donor	<input type="text"/>
Next of Kin (if not informant)	
Full Name of Donor's Next of Kin	<input type="text"/>
Next of Kin's Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip code	<input type="text"/>
Phone Number	<input type="text"/>
Additional Phone Number	<input type="text"/>
Email Address	<input type="text"/>
Personal Information on Donor	
Donor's handedness	<div><div><input type="radio"/> right</div><div><input type="radio"/> left</div></div> <div>reset</div>
Donor's height (ft)	<input type="text"/>

Donor's height (in)

Donor's weight

What hazardous substances, if any, was the donor exposed to?

Donor's Birth History

Donor's birth order

- ☐ first
- ☐ second
- ☐ third
- ☐ fourth
- ☐ fifth
- ☐ other

reset

Time of day donor was born



Now

H:M

Donor's birth weight

Please indicate any complications during the pregnancy or birth of the donor.

- ☐ Difficulty in conception
- ☐ In Vitro Fertilization
- ☐ Measles
- ☐ German Measles
- ☐ Excessive swelling
- ☐ Flu
- ☐ Toxemia
- ☐ Excessive vomiting
- ☐ Emotional problems
- ☐ Anemia
- ☐ Abnormal weight gain
- ☐ Vaginal bleeding
- ☐ High blood pressure
- ☐ Rh incompatibility
- ☐ Labor induced with Oxytocin (ptocin)?
- ☐ Prolonged labor
- ☐ Prolonged delivery
- ☐ Prematurity
- ☐ Prolonged pregnancy
- ☐ Low oxygen
- ☐ Infections
- ☐ Seizures
- ☐ Trauma
- ☐ Forceps
- ☐ Breech
- ☐ Jaundice
- ☐ Anesthesia during delivery
- ☐ Incubator
- ☐ Caesarean section

APGARS during delivery

- ☐ 1 minute
- ☐ 5 minutes
- ☐ 10 minutes

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Describe medications used during pregnancy.

- ☐ prescription
- ☐ non prescription
- ☐ none

Indicate whether cigarettes were smoked during pregnancy.

- ☐ no
- ☐ yes

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Indicate whether alcohol was used during pregnancy.

☐ no
☐ yes

reset

Were any other substances used during pregnancy?
(cocaine, marijuana, etc.)

☐ no
☐ yes

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Donor's Medical History

Donor's doctor's name

Donor's doctor's speciality

Doctor's address

State

Zip Code

Doctor's Telephone number

Doctor's Fax number

Did the donor have any of the following medical conditions or characteristics?

Irregular or unusual body or facial features

☐ no
☐ yes

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Recurrent ear infections

☐ no
☐ yes

reset

Vision problems

☐ no
☐ yes

reset

Difficulty sleeping

☐ no
☐ yes

reset

Irregular response to temperature	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Irregular response to pain	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Hyperlexia (superior reading skills)	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Special food interest/preoccupation	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Allergies	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Enlarged head circumference	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Gastrointestinal problems (GERD, loose stools)	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Medications		
<p>Please fill out the information below or list the name and phone number of the person that we can contact to retrieve records. (You may also note, "refer to medical records" if provided.)</p>		
<p>Please list the medication (s), approximate dates of usage, dosage, and specify whether it was effective.</p>	<div></div>	Expand
Did the donor have a history of seizures?	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset

Please either send, fax, or email the donor's immunization records (whichever method is easiest for you). You can also choose to provide the name and phone number of the person that we can contact to retrieve records.

Expand

Major / Recent Medical or Psychiatric Hospitalizations.
Please fill in information below or attach medical records or provide the name and phone number of the person that we can contact to retrieve records. Permission to access records may be required.

- ☐ no
☐ yes

reset

Reason for admission

Information Regarding Donor's Death

What is the time of the donor's death?

  H:M

What is the date of the donor's death?

  M-D-Y

What was the primary cause of death?

What were the contributing causes of death, if any?

Was a complete autopsy performed?

- ☐ no
☐ yes

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If yes, will you be sending, emailing, or faxing a copy of the autopsy? (You may also note, "refer to medical records" if provided.

- ☐ Sending
☐ Emailing
☐ Faxing

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Please list the name of the Coroner or Medical Examiner and County.

Additional Information for Researchers

Was the donor enrolled in any biological, genetics, or response to medication research studies? If yes, please send, email, or fax records and all data to us. You can also choose to provide the name and phone number of the person that we can contact to retrieve records.

- ☐ no
☐ yes

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Was the donor involved in any specific training or treatment programs, such as ABA, TEAACH, Speech or Occupational Therapy Programs? If yes, please send, fax, or email records to us, or provide the name and phone number of the person we can contact to retrieve records.

☐ no
☐ yes

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Family History

Are/Were any of the following conditions present in the donor, donor's brother(s)/sister(s), donor's maternal relatives, and/or donor's paternal relatives? (Example: donor's maternal relatives include donor's mother, aunt, uncle, grandmother etc. on the mother's side). If yes, under "specify", list the member of the family/relative that is diagnosed with the condition. If the brother(s)/sister(s) has the condition, please indicate whether they are identical/fraternal twins or halfbrother(s)/sister(s).

Allergies

☐ no
☐ yes

[reset](#)

Asthma

☐ no
☐ yes

[reset](#)

Frequent ear/sinus infections

☐ no
☐ yes

[reset](#)

Hearing problem

☐ no
☐ yes

[reset](#)

Lupus

☐ no
☐ yes

[reset](#)

Multiple Sclerosis

☐ no
☐ yes

[reset](#)

Rheumatoid Arthritis

☐ no
☐ yes

[reset](#)

Colitis, Irritable Bowl, Spastic Colon

☐ no
☐ yes

[reset](#)

Celiac Disease	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Diabetes	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Thyroid Problems	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Immunodeficiency Problems	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Tics or Tourette Syndrome	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Epilepsy	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Autism/ASD/Asperger Syndrome	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Difficulty with Social Interaction	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Speech Problems (includes slow development in verbal skills)	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Repetitive Behavior	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Unusually Focused on Special Interests (includes portraying unusual expertise on a topic)	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset

Intellectual Disability/Mental Handicap	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Specific Learning Disabilities (dyslexia, dyspraxia, etc.)	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
ADD/ADHD	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Attention Problems	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Heperactivity	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Impulsive Behavior	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Behavior Problems/Conduct/Disorder/Oppositional/Defiant Disorder	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Excessive Aggression	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Substance Abuse Problems	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Chemical Abuse	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset
Alcohol Dependency	<div><input type="radio"/> no</div> <div><input type="radio"/> yes</div>	reset

Mood Swings	<input type="radio"/> no <input type="radio"/> yes	reset
Depression	<input type="radio"/> no <input type="radio"/> yes	reset
Anxiety	<input type="radio"/> no <input type="radio"/> yes	reset
Obsessive Compulsive Disorder	<input type="radio"/> no <input type="radio"/> yes	reset
Psychosis	<input type="radio"/> no <input type="radio"/> yes	reset
Bipolar Disorder	<input type="radio"/> no <input type="radio"/> yes	reset
List other conditions not mentioned here.	<input type="text"/>	
Epidemiological Research		
What is the mother's ethnicity?	<input type="checkbox"/> White Northern European <input type="checkbox"/> Black African <input type="checkbox"/> Asian (e.g. India, Pakistan) <input type="checkbox"/> White Mediterranean <input type="checkbox"/> Afro-American <input type="checkbox"/> South-East Asian (e.g. China, Japan) <input type="checkbox"/> White East European <input type="checkbox"/> Caribbean <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic Spanish/Portugese <input type="checkbox"/> HIspanic South American <input type="checkbox"/> Pacific Islander	
If the mother is of mixed origin or if ethnicity is not listed above, please indicate here.	<input type="text"/>	

Please list the mother's country of birth.

What is the father's ethnicity?

- ☐ White Northern European
- ☐ Black African
- ☐ Asian (e.g. India, Pakistan)
- ☐ White Mediterranean
- ☐ Afro-American
- ☐ South-East Asian (e.g. China, Japan)
- ☐ White East European
- ☐ Caribbean
- ☐ American Indian
- ☐ Hispanic Spanish/Portugese
- ☐ Hispanic South American
- ☐ Pacific Islander

If the father is of mixed origin or if ethnicity is not listed above, please indicate here.

Please list the father's country of birth.

How would you like to receive new research information?

- ☐ Updates on our website
- ☐ Updates through email
- ☐ Updates through regular mail

Would you like to be in touch with other donor families within the tissue research programs network?

- ☐ In your state
- ☐ In the U.S. and other countries
- ☐ Through a secure section of a website

How did you hear about the BEARS Tissue Program?

Costs

If you have incurred costs in addition to this brain tissue donation, please note on this page and send us receipts for reimbursement.

Submit

