QUINTE HEALTHCARE CORPORATION

Appendix B - Part 1

CJD Risk Assessment Tool/Pre-op Check List

To be completed for all Neurosurgical/Spinal/Ophthalmological surgeries by surgeon along with surgical consent form.

COMPLETION OF THIS CJD RISK ASSESSMENT TOOL BEFORE SURGERY MUST BE CONFIRMED BEFORE THE SURGERY CAN PROCEED.

1. Does the patient have known/suspected Creutzfeldt-Jacob Disease? **YES □*** **NO □**
2. Does the patient have a rapidly progressive dementia, with myoclonus and ataxia, not yet diagnosed? **YES□*** **NO □**
3. Is there a family history of CJD? **YES □*** **NO □**
4. Is there a family history of any other inheritable Spongiform Encephalopathy (Gerstmann-Straussler-Scheinker (GSS) or Fatal Familial Insomnia (FFI))? **YES □*** **NO □**
5. Has the patient ever received any human pituitary growth hormone therapy? **YES□**** **NO□**
6. Does the patient have a history of receiving any human dura graft (until1992 for Lyodura grafts, until 1997 for Tutoplast Dura grafts) ? **YES □ **** **NO □**
7. Has Patient been exposed, via contact with instruments, to high –infectivity tissue of a confirmed CJD patient**?** **YES □ **** **NO □**
8. Is patient recipient of a corneal graft originating in a jurisdiction that does not require graft donors to be screened for neurological diseases? **YES □ **** **NO □**

***IF "YES" TO ANY OF THESE QUESTIONS, PATIENT IS "HIGH RISK PATIENT".**
**** IF "YES" TO ANY OF THESE QUESTIONS, CONSIDER PATIENT AS "AT RISK PATIENT".**
NOTIFY YOUR MANAGER, MEDICAL DEVICE REPROCESSING DEPARTMENT, AND INFECTION CONTROL.
REVIEW INFECTION CONTROL POLICY 5.20.

Surgical Procedure: ____

Date:______________________

PHYSICIAN SIGNATURE__________________________________