

4. Health Questionnaire

Blood donation should be safe for both the donor and the eventual recipient of the blood donated. The following questions will help us determine whether it is safe for YOU to donate blood today, and whether the blood is likely to be safe enough to give to a sick person. We cannot rely entirely on laboratory tests, as they may not always be able to detect infectious agents and other problems, so please answer the following questions TRUTHFULLY. Thank you!

Please check “✓” in the boxes and qualify any ‘Yes’ response by underlining the specific item that applies.

1. Are you not feeling well today, i.e. fever, cough, headache or cold? Yes No
2. Have you ever been deferred as a blood donor or told not to donate blood? Yes No
If Yes, for what reason? _____
3. Are you taking drugs for high blood pressure, diabetes, or asthma? Yes No
4. Do you have a history of epilepsy, stomach ulcer, or tuberculosis? Yes No
5. Have you taken medication or been vaccinated in the last 4 weeks? Yes No
If Yes, please give details _____
6. Have you had jaundice, liver disease, or a positive blood test for hepatitis? Yes No
7. Do you have sickle cell disease, e.g. SS, SC, and Sβthal? Yes No
8. Have you ever taken self-injected drugs or been diagnosed as a drug addict? Yes No
9. Have you in the last 12 months had an injection in a place that is not a hospital or clinic; skin scarring/tattoo or cutting by traditional healer, including circumcision? Yes No
10. Have you had dental treatment in the last 1 week? Yes No
11. Have you in the past 6 months had a major surgical operation? Yes No
12. Have you in the last 6 months received blood or blood product transfusion? Yes No
13. Have you in the last 6 months lost more than 5kgs due to illness? Yes No
14. Have you in the last 6 months had unprotected sex with more than one partner or have paid/been paid to have sex? Yes No
15. Have you ever had gonorrhoea or other sexually transmitted disease? Yes No
16. Have you in the last 6 months had sex with a homosexual? Yes No
17. Have you or your partner ever tested positive for HIV (AIDS) or hepatitis? Yes No
18. After blood donation, are you going to take part in any vigorous activity, such as climbing, driving a heavy vehicle or work at hazardous or heights? Yes No
19. Are you pregnant, breast-feeding or had a miscarriage in the past 12 months? Yes No

If the donor answers ‘YES’ to any of these questions refer to the “*Donor Selection Criteria Guide for Donor Attendants*” in the Donor Selection Manual to determine if the donor can be accepted.

Donor Declaration

I confirm that the information I have provided regarding my current state of health, previous illnesses, medication history, and sexual health are TRUE and CORRECT to the best of my knowledge. I understand my blood will be tested for HIV, Hepatitis B, Hepatitis C and Syphilis and I have no reason to believe I am a carrier of any. I understand that any incorrect answer to the question above may harm my health or that of a person who will receive my blood. I promise to notify the Blood Service/Blood Bank of any change to the information I have provided as soon as I am aware of it.

.....
Donor's Signature

.....
Counsellor's Signature

.....
Date



National Blood Transfusion Service Donor Clinical Record

Session Number _____ Date _____ Venue _____

1. Personal Data

1.1 First Name _____ 1.2 Last Name _____
 1.3 Date of Birth _____ 1.4 Sex Male Female
 1.5 Address (Residence) _____
 1.6 Address (Workplace) _____
 1.7 Occupation _____
 1.8 Phone Number _____ 1.9 Email _____

2. Voluntary Donors Only

2.1 Have you donated blood before? Yes No 2.2 If Yes, when was the last time? _____
 2.3 How many times as Voluntary _____ Replacement _____ 2.4 Donor Card # _____

3. Replacement/Family Donors Only

3.1 Name of Patient _____
 3.2 Hospital _____ 3.3 Ward _____
 3.4 Your relationship to Patient _____ 3.5 How many times have you donated? _____

Clerking Officer..... Signature.....

Section 4 →

Office Use Only

5. Donor Selection

5.1 Appearance: Passed Failed 5.2 Medical History: Passed Failed
 5.3 Wt _____ kg 5.4. Blood Pressure _____ mmHg 5.5 Pulse _____ bpm
 5.6 Hb by CuSO4 Passed Failed 5.7 Hb checked _____ g/dL
 5.8. HBsAg _____ 5.9. HCV _____
 5.10 Outcome of Screening:
 Qualifies to Donate Disqualified Deferred for _____ (duration)

Comments: _____

Name of Nurse..... Signature.....

6. Blood Collection

6.1 Donation Number:
 6.2 Outcome of Phlebotomy: Successful
 Unsuccessful Underbled Venous Access Donor Reaction

Name of Nurse..... Signature.....