

IDENTITY:

DONOR ID NUMBER :
FULL NAME :
FORMER SURNAME :
SEX, DATE OF BIRTH:
TITLE :
TOTAL DONATIONS :
PHONE NO. :
ADDRESS :

Donation
Number

DATE :

DONOR SIGNATURE :

Donor Services Comments

Will you accept Text Messages from IBTS? Y N
Will you accept Emails from IBTS?

Reg. Clerk Signature

RDI carried out? Y N

Donor: Accepted Deferred

Canteen Pre-Donation? Y N

RGN / DA Signature

Deferrals:

Deferral Code	Date From	Initials
CNM/RGN		

LAST DONATION:

Donation No. : Date :
Phlebotomy :

TEST RESULTS: (Historical)

ABO/RH :
PAED USE :

CURRENT DONATION:

Donation Source :
Donation & Pack Type :

Cap. Hb _____ A/N _____ Sig _____ RGN
DA

Ven. Hb _____ A/N _____ Sig _____ RGN
DA

Comments:

VP 1 :Sig _____	Scales:	Agitator:	Pilot Tubes Check <input type="checkbox"/>
L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> RGN <input type="checkbox"/> DA <input type="checkbox"/>	Timer:	Heatsealer:	RGN <input type="checkbox"/> DA <input type="checkbox"/>
Discontinued: Yes <input type="checkbox"/>	Bedside:		Packs Label Check <input type="checkbox"/>
Donation <input type="checkbox"/> FBC <input type="checkbox"/> S.O. <input type="checkbox"/>			RGN <input type="checkbox"/> DA <input type="checkbox"/>
Adjusted: During VP <input type="checkbox"/>	Labelling:		Heatsealed by: RGN <input type="checkbox"/> DA <input type="checkbox"/>
Immediately Post VP <input type="checkbox"/>	Packs <input type="checkbox"/> Initials _____		
During Donation <input type="checkbox"/>	Pilot Tubes <input type="checkbox"/> Initials _____		Linked By: RGN <input type="checkbox"/> DA <input type="checkbox"/>
RGN <input type="checkbox"/> DA <input type="checkbox"/>	Start Time:	Stop Time:	
VP 2 :Sig _____	Pack Batch No:		Comment Code: Weight
L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> RGN <input type="checkbox"/> DA <input type="checkbox"/>			TU Code: W/M Alarmed <input type="checkbox"/>
Discontinued: Yes <input type="checkbox"/>	Needle 1 Removed: RGN <input type="checkbox"/> DA <input type="checkbox"/>		Verification <input type="checkbox"/> RGN <input type="checkbox"/> DA <input type="checkbox"/> DC <input type="checkbox"/>
Donation <input type="checkbox"/> FBC <input type="checkbox"/> S.O. <input type="checkbox"/>	Needle 2 Removed: RGN <input type="checkbox"/> DA <input type="checkbox"/>		Correction <input type="checkbox"/> RGN <input type="checkbox"/> DA <input type="checkbox"/>
Adjusted: During VP <input type="checkbox"/>			
Immediately Post VP <input type="checkbox"/>			
During Donation <input type="checkbox"/>			
RGN <input type="checkbox"/> DA <input type="checkbox"/>			

DONOR DECLARATION

- Today, I read or listened to, understood and completed this Questionnaire. All the information I provided is true and accurate to the best of my knowledge.
- Today, I read or listened to and understood the Blood Safety and Blood Donation Information. To the best of my knowledge I am not at risk of the infections listed nor of transmitting these infections.
- I understand the nature of the donation process and the risks involved as described. I had an opportunity to ask questions and had satisfactory responses to any questions I asked. I consent to proceed with the donation process.
- I agree that my blood will be tested for HIV, hepatitis and other infectious agents and a small sample of blood will be stored. I understand that I will be notified of any results that may affect my health.
- I entrust my blood donation to the Irish Blood Transfusion Service to be used for the benefit of patients. This may be by direct transfusion to a patient, or indirectly as described.
- If I develop **any** illness after donating, I will **immediately** phone one of the Medical Staff in Dublin or Cork as this illness may have consequences for the patients who will receive my donation.
- I understand the IBTS will process information about me, my health, my attendances and my donations as explained in the donor information leaflets.
- I consent to the IBTS obtaining further details of illnesses or treatments from the Doctor/Hospital concerned if considered necessary to establish my eligibility to donate.

DONOR SIGNATURE: IBTS STAFF SIGNATURE:

Please read carefully and tick ✓ Yes or No. If you are uncertain of any answer leave the box blank.

Are You:

	Yes	No
1. Well and healthy at present?	<input type="checkbox"/>	<input type="checkbox"/>
2. Involved in a hazardous occupation or hobby?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 48 hours have you:

	Yes	No
3. Taken an anti-inflammatory?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 5 days have you:

	Yes	No
4. Taken aspirin or any tablet with aspirin in it?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 4 weeks have you:

	Yes	No
5. Been in contact with anyone with an infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
6. Taken any tablets or medicines other than the pill or HRT for the menopause?	<input type="checkbox"/>	<input type="checkbox"/>
7. Had treatment with Proscar, Propecia, Roaccutane, Isotrex, Retin-A or Zorac?	<input type="checkbox"/>	<input type="checkbox"/>
8. Had treatment from a dentist?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 8 weeks have you:

	Yes	No
9. Had a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 3 months have you:

	Yes	No
10. Had any illness or received any treatment from a doctor, nurse or other health care professional?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 4 months have you:

	Yes	No
11. Had acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>
12. Had ear, face or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
13. Had a tattoo or cosmetic treatment that involved piercing the skin?	<input type="checkbox"/>	<input type="checkbox"/>
14. Had an endoscopy (scope)?	<input type="checkbox"/>	<input type="checkbox"/>
15. Been in close contact with a person with hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had or been treated for a sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 12 months have you:

	Yes	No
17. Taken medication to prevent HIV infection (pre/post exposure prophylaxis, PrEP/PEP)?	<input type="checkbox"/>	<input type="checkbox"/>
18. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth or onto broken skin?	<input type="checkbox"/>	<input type="checkbox"/>

Your COMPLETE HONESTY in answering all questions is essential for your safety and the safety of patients who receive your blood. ALL INFORMATION YOU PROVIDE IS CONFIDENTIAL

Have you EVER:

	Yes	No
19. Had a blood transfusion - red cells, platelets or plasma?	<input type="checkbox"/>	<input type="checkbox"/>
20. Had or been treated for syphilis or gonorrhoea?	<input type="checkbox"/>	<input type="checkbox"/>
21. Been diagnosed with or treated for Haemochromatosis?	<input type="checkbox"/>	<input type="checkbox"/>

Have you:

	Yes	No
22. Had any brain or spinal cord surgery in the UK* since 01 January 1980?	<input type="checkbox"/>	<input type="checkbox"/>

UK includes Northern Ireland, England, Scotland, Wales, the Channel Islands and the Isle of Man.

Since your last donation have you:

	Yes	No
23. Had any serious illness or medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
24. Been treated by a Dermatologist or skin specialist?	<input type="checkbox"/>	<input type="checkbox"/>
25. Had an operation or any surgery?	<input type="checkbox"/>	<input type="checkbox"/>
26. Had jaundice or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
27. Been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?	<input type="checkbox"/>	<input type="checkbox"/>
28. Taken care of or handled monkeys or their body fluids?	<input type="checkbox"/>	<input type="checkbox"/>

After your last donation did you:

	Yes	No
29. Faint or have any problems?	<input type="checkbox"/>	<input type="checkbox"/>

Travel:

	Yes	No
30. In the past 12 months OR since your last donation (if less than 12 months ago) have you been outside of Ireland or the UK for any reason e.g. business or holidays?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you EVER had malaria or an unexplained fever or an illness which you could have picked up while travelling?	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you EVER lived in a malarial area for 6 months or more?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you EVER lived in or visited Mexico, Central or South America for 4 weeks or more?	<input type="checkbox"/>	<input type="checkbox"/>

For Females Only: Have you

	Yes	No
34. Been pregnant in the past 12 months or are you pregnant at present?	<input type="checkbox"/>	<input type="checkbox"/>
35. Received a donated egg or embryo since 01 January 1980?	<input type="checkbox"/>	<input type="checkbox"/>

NEVER DONATE TO GET A TEST FOR HIV OR HEPATITIS IF YOU DO YOU RISK INFECTING OTHER PEOPLE

36. For all Donors:

	Yes	No
• Are you donating JUST to be tested for HIV or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you or your partner have HIV or HTLV?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you or your partner or close household contacts have hepatitis B or hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you EVER injected or have you been injected with non-prescribed drugs - EVEN ONCE OR A LONG TIME AGO? This includes body building drugs & injectable tanning agents.	<input type="checkbox"/>	<input type="checkbox"/>
• Have you EVER been given money or drugs for sex?	<input type="checkbox"/>	<input type="checkbox"/>

37. For Males only: In the past 12 months

	Yes	No
Have you had oral or anal sex with another male, even if it was 'safer sex' using a condom or pre-exposure prophylaxis (PrEP)?	<input type="checkbox"/>	<input type="checkbox"/>

38. For Females only: In the past 12 months

	Yes	No
Have you had sex with a male who has EVER had oral or anal sex with another male, even if it was 'safer sex' using a condom or pre-exposure prophylaxis (PrEP)?	<input type="checkbox"/>	<input type="checkbox"/>

39. In the past 12 months, have you had sex with:

	Yes	No
• Anyone who has HIV, hepatitis B or C, or HTLV?	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone who has syphilis or any other sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone who has EVER been given money or drugs for sex?	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone (including your current partner) who has EVER had sex in parts of the world where HIV is very common? This includes Africa and South East Asia.	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone who has EVER injected drugs?	<input type="checkbox"/>	<input type="checkbox"/>

All the above apply even if a condom or other form of protection was used.

40. In the past 12 months have you:

	Yes	No
• Been imprisoned?	<input type="checkbox"/>	<input type="checkbox"/>
• Snorted cocaine or any other drug?	<input type="checkbox"/>	<input type="checkbox"/>

Donors 25 years or younger:

	Yes
I would like to give a blood sample to join the BONE MARROW Registry.	<input type="checkbox"/>
I have read the associated information leaflet.	<input type="checkbox"/>