

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"/>	Labelling:		RGN <input type="checkbox"/> DA <input type="checkbox"/>
Adjusted: During VP <input type="checkbox"/>	Packs <input type="checkbox"/> Initials _____		Heatsealed by: RGN <input type="checkbox"/> DA <input type="checkbox"/>
Immediately Post VP <input type="checkbox"/>	Pilot Tubes <input type="checkbox"/> Initials _____		Linked By: RGN <input type="checkbox"/> DA <input type="checkbox"/>
During Donation <input type="checkbox"/>	Start Time: Stop Time:		Comment Code: Weight
RGN <input type="checkbox"/> DA <input type="checkbox"/>	Pack Batch No:		TU Code: W/M Alarmed <input type="checkbox"/>
VP 2 :Sig _____	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"/>
L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> RGN <input type="checkbox"/> DA <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"/>
Discontinued: Yes <input type="checkbox"/>			
Donation <input type="checkbox"/> FBC <input type="checkbox"/> S.O. <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.

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

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

Are You: Yes No

1. Well and healthy at present?

2. Involved in a hazardous occupation or hobby?

Is Your: Yes No

3. Current gender different from that assigned to you at birth?

In the past 48 hours have you: Yes No

4. Taken an anti-inflammatory?

In the past 5 days have you: Yes No

5. Taken aspirin or any tablet with aspirin in it?

In the past 4 weeks have you: Yes No

6. Been in contact with anyone with an infectious disease?

7. Taken any tablets or medicines other than the pill or HRT for the menopause?

8. Had treatment with Proscar, Propecia, Roaccutane, Isotrex, Retin-A or Zorac?

9. Had treatment from a dentist?

In the past 8 weeks have you: Yes No

10. Had a vaccination?

In the past 3 months have you: Yes No

11. Had any illness or received any treatment from a doctor, dentist, nurse or other health care professional?

In the past 4 months have you: Yes No

12. Had acupuncture?

13. Had ear, face or body piercing?

14. Had a tattoo or cosmetic treatment that involved piercing the skin?

15. Had an endoscopy (scope)?

16. Been in close contact with a person with hepatitis or monkeypox?

17. Had or been treated for a sexually transmitted infection?

18. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth or onto broken skin?

Have you EVER: Yes No

19. Had a blood transfusion - red cells, platelets or plasma?

20. Had or been treated for syphilis or gonorrhoea?

21. Been diagnosed with or treated for Haemochromatosis?

Have you: Yes No

22. Had any brain or spinal cord surgery in the UK* since 01 January 1980?

* 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?

24. Had jaundice or hepatitis?

25. Had monkeypox?

26. Been treated by a Dermatologist or skin specialist?

27. Had an operation or any surgery?

28. Been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?

29. Taken care of or handled monkeys or their body fluids?

After your last donation did you: Yes No

30. Faint or have any problems?

Travel: Yes No

31. 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?

32. Have you EVER had malaria or an unexplained fever or an illness which you could have picked up while travelling?

33. Have you EVER lived in a malarial area for 6 months or more?

34. Have you EVER lived in or visited Mexico, Central or South America for 4 weeks or more?

For Female donors and those who answered yes to Q3, Have you: Yes No

35. Been pregnant in the past 12 months or are you pregnant at present?

36. Received a donated egg or embryo since 01 January 1980?

37. For all Donors: Yes No

• Are you donating **JUST** to be tested for HIV or hepatitis?

• Do you or your partner have HIV or HTLV?

• Do you or your partner or close household contacts have hepatitis B or hepatitis C?

• 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.

• Have you **EVER** been given money or drugs for sex?

38. In the past 4 months, have you had oral, vaginal or anal sex with: Yes No

• Anyone who has HIV, hepatitis B or C, or HTLV?

• Anyone who has syphilis or any other sexually transmitted infection?

• Anyone who has **EVER** been given money or drugs for sex?

• Anyone who has **EVER** injected drugs?

39. In the past 4 months have you had: Yes No

• A new sexual partner* **OR** more than one sexual partner?

IF YES: Did you have anal sex?

*A new sexual partner is someone you did not have sex with before, or a person with whom you resumed a sexual relationship in the past 4 months.

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

40. In the past 4 months have you: Yes No

• Snorted cocaine or any other drug?

• Taken medication to prevent HIV infection (pre/post exposure prophylaxis, PrEP/PEP)?

• Taken part in Chemsex i.e. have you used drugs (other than cannabis, alcohol or Viagra) before or during sex to enhance sexual experience?

IF YES: Did you inject or were you injected with drugs?

Donors 25 years or younger: Yes

I would like to give a blood sample to join the **BONE MARROW** Registry.

I have read the associated information leaflet.