Blood Donor Questionnaire & Consent Form

Name and address of blood bank:

License no: Blood unit no:

Please answer the following questions correctly. This will help to protect you and the patient who receives your blood.

Name :	☐ Male	☐ Female
Date of Birth: Age	Father's/Husband's Name :	
Occupation	Organization:	
Address for communication:		
Telephone:	Mobile No. :	
Would you like us to call you on your mobile:	☐ Yes	☐ No
Fax No. (if any) :	Email (if any):	
Have you donated previously	☐ Yes	☐ No
Your blood group:	Time of last meal:	
Did you have any discomfort during/after donation?	☐ Yes	☐ No

- Do you feel well today?: ☐ Yes ☐ No
- Did you have something to eat in the last 4 hours? ☐ Yes ☐ No
- Did you sleep well last night?: ☐ Yes ☐ No
- Have you any reason to believe that you may be infected: By Hepatitis, Malaria, HIV/AIDS, and/or venereal disease? ☐ Yes ☐ No
- In the last 6 months have you had any history of the following:

☐ Unexplained weight loss
☐ Repeated Diarrhea
☐ Swollen glands
☐ Continuous low-grade fever

- In the last 6 months have you had any:-

☐ Tattooing
☐ Ear Piercing
☐ Dental Extraction

- Do you suffer from or have suffered from any of the following diseases?

☐ Heart Disease ☐ Lung disease ☐ Kidney Disease
☐ Cancer/Malignant Disease ☐ Epilepsy
☐ Diabetes ☐ Tuberculosis ☐ Malaria
☐ Abnormal bleeding tendency ☐ Hepatitis B/C
☐ Allergic Disease ☐ Fainting spells ☐ Jaundice
☐ Sexually Trans. Diseases ☐ Typhoid (last 1 yr.)

- Are you taking or have taken any of these in the past 72 hours?

☐ Antibiotics ☐ Aspirin ☐ Alcohol
☐ Steroids ☐ Vaccinations
☐ Dog Bite/Rabies vaccine (1 yr.)

- Is there any history of surgery or blood transfusion in the past 6 months?

☐ Major Surgery ☐ Minor Surgery ☐ Blood Transfusion

- For women donors,
  Are you pregnant ☐ Yes ☐ No
  Have you had an abortion in the last 3 months ☐ yes ☐ No
  Do you have a child less than one year old? ☐ Yes ☐ No
  Is the child still breast-feeding? ☐ Yes ☐ No
  Are you having your periods today? ☐ Yes ☐ No

- Would you like to be informed about any abnormal test result at the address furnished by you?
  ☐ Yes ☐ No
- Have you read and understood all the information presented and answered all the questions truthfully, as any incorrect statement or concealment may affect your health or may harm the recipient.
  ☐ Yes ☐ No

I understand that

(a) blood donation is a totally voluntary act and no inducement or remuneration has been offered

(b) Donation of blood/components is a medical procedure and that by donating voluntarily, I accept the risk associated with this procedure.

(c) my blood will be tested for Hepatitis B, Hepatitis C, Malarial Parasite, HIV/AIDs and venereal diseases in addition to any other screening tests required to ensure blood safety

I prohibit any information provided by me or about my donation to be disclosed to any individual or government agency without my prior permission.

Date: _______ Time: ____________
Donor's signature: ____________________________________

General Physical Examination:
Weight________________ Pulse __________________
Hb ________________ BP __________________
Temperature ____

Accept ☐ Defer ☐ Reason __________________________

Signature of Medical Officer:

Five minutes of your time + 350 ml. of your blood = One life saved.