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? Y ☐ N ☐

Reg. Clerk Signature

RDI carried out? Y ☐ N ☐

Donor: **Accepted** ☐ **Deferred** ☐

RGN / ADA Signature

Deferrals:

Deferral Code	Date From	Initials
		CNM / RGN

LAST DONATION:

Donation No. :

Date :
Phlebotomy :

TEST RESULTS: (Historical)

CMV: POS ☐ NEG ☐
ABO/RH :
PAED USE :

CURRENT DONATION:

Donation Source :
Donation Type :
Pack Type :
Blood Pressure :
Pulse Rate :

Additional Test (s)

Comments:

VP 1 :Sig _____

L Arm ☐ **R Arm** ☐ RGN☐ ADA☐

Discontinued: Yes ☐

Donation ☐ **FBC** ☐ **S.O.** ☐ ____

VP 2 :Sig _____

L Arm ☐ **R Arm** ☐ RGN☐ ADA☐

Discontinued: Yes ☐

Donation ☐ **FBC** ☐ **S.O.** ☐ ____

Labelling:
Packs & Tubes ☐ RGN☐ ADA☐
Verified ☐ RGN☐ ADA☐

Start Time:	Stop Time:

Heatsealer: _____
Heatsealed by: RGN☐ ADA☐

Product Tagged:
1: _____ RGN☐ ADA☐
2: _____ RGN☐ ADA☐

Scales:	Weight:

Linked By: RGN☐ ADA☐

TU Code:	Comment Code:

Needle Removed: RGN☐ ADA☐

Machine Number:

Machine Set-up: RGN☐ ADA☐

Lines Clamped: RGN☐ ADA☐

Machine Primed: RGN☐ ADA☐

Data Input Verification: RGN☐ ADA☐

Verification ☐ RGN☐ ADA☐
Correction ☐ RGN☐ ADA☐

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?	☐	☐
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?	☐	☐

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?	☐	☐
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. EVER been pregnant or are you pregnant at present?	☐	☐
36. Received a donated egg or embryo since 01 January 1980?	☐	☐

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

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.	☐