IDENTITY:

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

DATE :

DONOR SIGNATURE : .....

Donation Number

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 _____
L Arm ☐ **R Arm** ☐ **RGN** ☐ **DA** ☐
Discontinued: Yes ☐
Donation ☐ **FBC** ☐ **S.O.** ☐ ___

Adjusted: **During VP** ☐
Immediately Post VP ☐
During Donation ☐
RGN ☐ **DA** ☐

VP 2 : Sig _____
L Arm ☐ **R Arm** ☐ **RGN** ☐ **DA** ☐
Discontinued: Yes ☐
Donation ☐ **FBC** ☐ **S.O.** ☐ ___

Adjusted: **During VP** ☐
Immediately Post VP ☐
During Donation ☐
RGN ☐ **DA** ☐

Scales:	**Agitator:**
Timer:	**Heatsealer:**
Bedside: **RGN** ☐ **DA** ☐	
Labelling: **RGN** ☐ **DA** ☐	
Packs ☐ **Initials** _____	
Pilot Tubes ☐ **Initials** _____	
Start Time:	**Stop Time:**
Pack Batch No:	
Needle 1 Removed: **RGN** ☐ **DA** ☐	
Needle 2 Removed: **RGN** ☐ **DA** ☐	

Pilot Tubes Check ☐ **RGN** ☐ **DA** ☐	
Packs Label Check ☐ **RGN** ☐ **DA** ☐	
Heatsealed by: **RGN** ☐ **DA** ☐	
Linked By: **RGN** ☐ **DA** ☐	
Comment Code:	**Weight**
TU Code:	**W/M Alarmed** ☐
Verification ☐ **RGN** ☐ **DA** ☐ **DC** ☐	
Correction ☐ **RGN** ☐ **DA** ☐	

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 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?	☐	☐

In the past 48 hours have you:	Yes	No
3. Taken an anti-inflammatory?	☐	☐

In the past 5 days have you:	Yes	No
4. Taken aspirin or any tablet with aspirin in it?	☐	☐

In the past 4 weeks have you:	Yes	No
5. Had sex with anyone who has EVER had Zika Virus Infection - with or without protection?	☐	☐
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, 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. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth or onto broken skin?	☐	☐
16. Had an endoscopy (scope)?	☐	☐
17. Been in close contact with a person with hepatitis?	☐	☐
18. Had or been treated for a sexually transmitted infection?	☐	☐

In the past 5 years have you:	Yes	No
19. Taken medication to prevent HIV infection (pre/post exposure prophylaxis, PrEP/PEP)?	☐	☐

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
20. Had a blood transfusion - red cells, platelets or plasma?	☐	☐
21. Had or been treated for syphilis or gonorrhoea?	☐	☐
22. Been diagnosed with or treated for Haemochromatosis?	☐	☐

Since 01 January 1980 have you:	Yes	No
23. Had any operation, eye surgery, laser eye treatment or root canal treatment in the UK?	☐	☐
UK includes Northern Ireland, England, Scotland, Wales, the Channel Islands and the Isle of Man.		

Since your last donation have you:	Yes	No
24. Had any serious illness or medical condition?	☐	☐
25. Been treated by a Dermatologist or skin specialist?	☐	☐
26. Had an operation or any surgery?	☐	☐
27. Had jaundice or hepatitis?	☐	☐
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 Females only: 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?	☐	☐

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. 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)?	☐	☐

39. 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)?	☐	☐

40. In the past 12 months, have you had 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 had sex in parts of the world where HIV is very common? This includes Africa and South East Asia.	☐	☐
• Anyone who has EVER injected drugs?	☐	☐
All the above apply even if a condom or other form of protection was used.		

41. In the past 12 months have you:	Yes	No
• Been imprisoned?	☐	☐
• Snorted cocaine or any other drug?	☐	☐