WP Blood Transfusion Service
Do something remarkable

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CONFIDENTIAL DONOR QUESTIONNAIRE

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Please make sure that you complete all required sections carefully and honestly.

SECTION 1

Lifestyle Questionnaire:

Though personal, these questions don't aim to offend, but rather to identify potential risk to the recipient.

SECTION 2

Health Questionnaire:

Your safety is as important to us as the safety of the recipient. Therefore, you might not be able to donate if you answer 'yes' to any of these questions. The qualified nurse will discuss your answers with you.

SECTION 3

Contact Details and Donor Enrolment Form:

New donors must complete all sections of the questionnaire.

Regular blood donors should only complete section 3 if any personal information has changed.

PLEASE DO NOT DONATE BLOOD IF YOU MAY HAVE BEEN EXPOSED TO HIV/AIDS.

You may be endangering someone's life.
Never donate blood for personal health screening purposes.

Thank you for donating blood today!

Your donation could save at least three lives. Remarkable, isn't it? As a Service, we provide safe blood and blood products to those who need them. Please continue to make a difference by remaining a regular blood donor.

DONOR LABEL

BAR CODE

Section 1 | **LIFESTYLE QUESTIONNAIRE**

Please circle your answers.

Please read all questions carefully and answer honestly. Your answers will be treated confidentially.

1	Do you consider your blood safe to be transfused to a patient?	No	Yes	STAFF SECTION
2	**In the past 6 months have you:** Had a tattoo, body piercing, ear piercing or permanent make-up applied?	No	Yes	
	Had Raatib, ritual scarring, ritual piercing, ritual circumcision, blood sharing or been stabbed?	No	Yes	
	Taken antiretroviral (ARV's) medication, including Truvada?	No	Yes	
3	**For Health Care Workers and their partners only:** **In the past 6 months:** Have you or your sexual partner had a needle stick or skin penetrating injury; or had skin, eye or mouth contact with another person's blood?	No	Yes	
	The following questions are of a sexual nature. We ask these questions as sexual contact may cause infectious diseases like HIV/AIDS. "Sexual contact" refers to vaginal sex (contact between penis and vagina); oral sex (mouth or tongue contact with vagina, penis or anus) and anal sex (contact between penis and anus). Where applicable, please answer "Yes" to the following questions even if a condom was used:			
4	Do you have AIDS or are you HIV positive?	No	Yes	
	Have you ever had sexual contact with anyone who has AIDS or is HIV positive?	No	Yes	
	Are you only giving blood for an HIV test?	No	Yes	
5	**In the past 6 months (with or without a condom):** - Have you started having sexual contact with a new sexual partner?	No	Yes	
	- Have you had sexual contact with more than one person?	No	Yes	
	- To the best of your knowledge has your sexual partner had sexual contact with more than one person?	No	Yes	
	- Have you had sexual contact with someone whose sexual history you do not know?	No	Yes	
	- Have you had sexual contact with anyone who takes money, drugs or other favours for sex?	No	Yes	
	- Have you received money, drugs or other payment for sex?	No	Yes	
	- Are you a sex worker?	No	Yes	
	- Have you been sexually assaulted?	No	Yes	
6	**In the past 6 months:** Have you or your sexual partner had any sexually transmitted disease (STD) including genital herpes, syphilis, gonorrhoea (drop) or human papilloma virus?	No	Yes	
7	Have you or your sexual partner ever used recreational/street drugs by nose, mouth or injection needle?	No	Yes	

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DECLARATION : Please read and sign before donating blood.

1. I have read and understood the pamphlet "Important Information for Blood Donors".
2. To the best of my knowledge all the information supplied is the truth.
3. I understand that if I have not answered these questions truthfully this could endanger the patient and lead to legal proceedings against me. I undertake that should I for any reason deem my blood not safe for use, I will immediately inform WPBTS.
4. I consent to my blood being tested for Syphilis, Hepatitis B, Hepatitis C and HIV.
5. I understand that I will be informed of any test results that are important to my health or affect my ability to donate blood.
6. I accept that samples of my blood and / or donation data may be used on occasion for scientific research, the objective of which is to improve the safety of the blood supply to patient and donor health and well-being. On occasion the Service may permit researchers to request additional samples from me with my consent.
7. I confirm that I am 16 years of age or older.
8. I understand that the information on this form will be kept in a secure facility indefinitely under my donor code, not my name.
9. I understand the donation process and the possible risks involved as explained.
10. I consent to the administration of such fluids and medications as deemed necessary in the management of an untoward donor reaction.
11. I consent to the infusion of fluids, medications and re-infusion of my own blood components during apheresis collection procedures.
12. I consent to being offered information on the Service's Iron Replacement Programme and that any decision to take the iron replacement tablets rests with me.

Please do not sign until you have answered all the questions and read the declaration.

Cell number:	Tel number:
Name and surname:	
Date of birth:	
Donor's signature:	

FOR OFFICE USE:				
Interview done	No		Yes	
Signature: Phlebotomist				
Signature: Interviewer (only if interview was done)				

Section 2 | # HEALTH QUESTIONNAIRE

Please circle your answers.

Please read all questions carefully and answer honestly. Your answers will be treated confidentially.

#	Question			STAFF SECTION
1	Are you feeling well today?	No	Yes	
	In the last 4 hours have you had something to eat and drink?	No	Yes	
2	**Are you involved in any of the following:** Driving a public or heavy-duty vehicle, flying an aeroplane, working on scaffolding or using power tools?	No	Yes	
	Sky diving, deep-sea diving or mountaineering?	No	Yes	
3	**In the past 3 days:** Have you been to the dentist?	No	Yes	
	Have you taken any painkillers, anti-inflammatories or aspirin (Ecotrin)?	No	Yes	
	In the past 7 days: Have you had a cold, flu, sore throat, fever, infection or allergies?	No	Yes	
	In the past 30 days: Have you had diarrhoea or vomiting?	No	Yes	
	Have you taken Androcur, Proscar, Propecia, Roaccutane, Warfarin or Dabigtran Etexilate (Pradaxa)?	No	Yes	
4	**In the past 3 months:** Have you taken any medication (including traditional medication), injections or tablets?	No	Yes	
5	**In the past 6 months:** Have you or your sexual partner had a blood transfusion or received blood products or clotting factors?	No	Yes	
	Have you had acupuncture, botox or dry-needling?	No	Yes	
	Have you had a vaccination or immunization (inoculation)?	No	Yes	
	Have you taken part in a drug trial, vaccine trial, or clinical research?	No	Yes	
6	**In the past 6 months:** Have you had a surgical procedure or been admitted to hospital?	No	Yes	
	Are you scheduled to have surgery **in the next 6 weeks?**	No	Yes	
7	**In the past 2 years:** Have you taken (Neo) Tigason for skin problems?	No	Yes	
8	**Have you ever had:** High blood pressure?	No	Yes	
	Heart, lung, circulatory problems or a bleeding disorder?	No	Yes	
	Epilepsy, convulsions or strokes?	No	Yes	
	Cancer, skin cancer or leukaemia?	No	Yes	
	Diabetes, asthma, TB or kidney disease?	No	Yes	
9	Has your doctor ever advised you to donate blood for medical reasons (high iron, ‘thick blood’, polycythaemia or haemochromatosis)?	No	Yes	
10	**HEPATITIS:** Have you ever had yellow jaundice, hepatitis, liver disease or a positive test for hepatitis?	No	Yes	
	In the past 6 months have you been in contact or lived with anyone who has hepatitis (jaundice)?	No	Yes	
11	**MALARIA:** Have you been in a malaria area **in the last 3 months**?	No	Yes	
	Have you had malaria **in the last 3 years**?	No	Yes	
	Did you grow up in a malaria prevalent area?	No	Yes	
	If “yes”, have you been in any malaria area in the last 3 years?	No	Yes	
12	**VARIANT CREUTZFELD-JAKOB DISEASE: (also known as Mad Cow disease)** Have you ever had neuro surgery, received a dura mater (brain covering) graft or taken pituitary growth hormone?	No	Yes	
	Have you or your sexual partner ever received a tissue, cornea or organ transplant?	No	Yes	
	Were you residing in the United Kingdom for a total period of 12 months or longer between Jan. 1980 and Dec. 1996?	No	Yes	
13	Have you ever had any other serious illnesses, severe allergic reactions, tropical diseases or medication not mentioned above?	No	Yes	
14	Are you participating in a regular training or athletic programme?	No	Yes	
15	Have you ever injected yourself or been injected with illegal steroids (body building drugs)?	No	Yes	
16	**FOR WOMEN ONLY:** Are you pregnant or undergoing fertility treatment?	No	Yes	
	In the last 3 months have you had a baby, miscarriage or abortion?	No	Yes	
	Are you breastfeeding?	No	Yes	

FOR OFFICE USE:		
Blood pressure:	Pre	Post
Donor’s pulse:	Pre	Post
Hb:	g/dL	Sign

Donor set-up by:	BARCODE
Sample taken by:	
Needle removed by:	

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Section 3 | DONOR ENROLMENT FORM

First time donors: Complete fully

Regular donors: Only complete this page if your personal information has changed.

Surname:		Age:	Title:
First name:	Second name initials:	Female:	Male:
Date of birth: D D M M Y Y Y Y	ID no:		
Home address:			
		Postal code:	
Postal address:			
		Postal code:	
Telephone no's: H: C O D E	W: C O D E		
Cellphone no:			
Workplace name & address:			
		Postal code:	
E-mail address:			

Please circle your answers:

Language:	Eng	Afr	Other	Ethnic Group:	Asian	Black	Coloured	White
Have you ever attended a blood donor clinic or donated blood before?	Yes	No	No. of previous donations:					
If you have donated blood before, where:			When: Y Y Y Y					
Have you ever used a different name to donate blood?	Yes	No	If yes, state name used:					
Preferred place of donation:								
I hereby agree to receive notifications and reminders from WPBTS via:	E-mail	SMS	Written material	Phone calls				

I understand that all calls received from WPBTS will be recorded for quality purposes.

I hereby declare that I would like to enrol as a blood donor. Donor Signature: ______________ Date: ______________

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FOR OFFICE USE ONLY:

STATS CODE:	BARCODE
PANEL CODE:	
RESIGNATION CODE:	
COMMENTS:	DONOR LABEL

DEFERRAL REASON:	
RECEPTIONIST SIGNATURE:	DATE:
MEDICAL COMMENTS:	
SPECIAL INSTRUCTION:	
ATTACH MALARIA STICKER TO BLOOD PACK UNTIL (DATE):	
DONOR CODE:	

Iron replacement tablets taken:	YES		NO	
Signature: ______________				

Gifts received: ______________

Donor signature: ______________