Please check that your Name, Date of Birth, Address and Telephone Nos. are entered correctly.

IDENTITY:

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

Donation Number

DATE :

DONOR SIGNATURE : ..... ☐ Initials_____ MO / RGN / DA

Donor Services Comments

Will you accept Text Messages from IBTS? Y ☐ N ☐
Will you accept Emails from IBTS? ☐ ☐

Reg. Clerk Signature

EDI carried out? Y ☐ N ☐ Not Required ☐

Donor: Accepted ☐ Deferred ☐

MO / RGN Signature

Deferrals:

Deferral Code	Date From	Initials
		MO / 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 ☐ MO / RGN
Discontinued: Yes ☐
Donation ☐FBC ☐S.O. ☐ ____

VP 2 :Sig _____
L Arm ☐ R Arm ☐ MO / RGN
Discontinued: Yes ☐
Donation ☐FBC ☐S.O. ☐ ____

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

Start Time: | Stop Time:

Heatsealer: _____
Heatsealed by: MO / RGN / ADA

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

Scales: | Weight:

Linked By: RGN / ADA

TU Code: | Comment Code:

Needle Removed: MO / RGN / ADA

Machine Number:
Machine Set-up: RGN / ADA
Lines Clamped: RGN / ADA
Machine Primed: RGN / ADA
Data Input Verification: RGN / ADA

Verification ☐
Correction ☐
MO / RGN / ADA

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 blood. Signature: Date:

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 Platelet 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 (01) 432 2800 or Cork (021) 480 7400, as this illness may have consequences for the patients who will receive my blood.

DONOR SIGNATURE: ..... I.B.T.S. STAFF SIGNATURE: .....

SAMPLE ONLY

Your COMPLETE HONESTY in answering all questions is essential for the safety of patients who receive your blood. ALL INFORMATION YOU PROVIDE IS CONFIDENTIAL. Please read carefully and complete before donating by placing a tick ✓ in the appropriate box. If you are uncertain of any answer, leave the box blank and speak in confidence with a health care professional. A 'yes' answer to some questions may still mean that you will be eligible to donate.

Are You:	Yes	No
1. Well and healthy at present?	☐	☐
2. Having any treatment from a doctor, dentist, nurse or any other health care professional?	☐	☐
3. Involved in a hazardous occupation or hobby (e.g. bus driving, diving etc.)?	☐	☐

Have You:	Yes	No
4. Spent 12 months or more in total in the UK* in the years 1980 - 1996? **UK includes Northern Ireland, England, Scotland, Wales, the Channel Islands and the Isle of Man*	☐	☐
5. Had any operation, eye surgery, laser eye treatment or root canal treatment in the UK* since 01 January 1980?	☐	☐

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

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

In the past 4 weeks have you:	Yes	No
8. Taken any tablets or medication other than HRT or the pill?	☐	☐
9. Had treatment with Proscar, Propecia, Roaccutane, Isotrex, Retin-A or Zorac?	☐	☐
10. Had treatment from a dentist?	☐	☐
11. Been in contact with an infectious disease?	☐	☐

In the past 8 weeks have you:	Yes	No
12. Had a vaccination?	☐	☐

In the past 4 months have you:	Yes	No
13. Had acupuncture?	☐	☐
14. Had ear, face or body piercing?	☐	☐
15. Had a tattoo or cosmetic treatment that involved piercing the skin?	☐	☐
16. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth?	☐	☐
17. Had an endoscopy (scope)?	☐	☐
18. Been in close contact with a person with hepatitis?	☐	☐

In the past 12 months have you:	Yes	No
19. Seen a doctor for any reason?	☐	☐
20. Had any medical tests or treatments?	☐	☐
21. Had an operation or any surgery?	☐	☐

22. Have you EVER had any of the following:	Yes	No		Yes	No
Allergy/Asthma?	☐	☐	Epilepsy/Fits?	☐	☐
Cancer?	☐	☐	Fainted?	☐	☐
Diabetes?	☐	☐	Heart Condition?	☐	☐
Dizzy Spells?	☐	☐	Operation/Surgery?	☐	☐

Have you EVER:	Yes	No
23. Had any serious illness?	☐	☐
24. Had jaundice or hepatitis?	☐	☐
25. Received a blood transfusion?	☐	☐
26. Had a sexually transmitted infection?	☐	☐
27. Had or been treated for syphilis or gonorrhoea?	☐	☐
28. Had an organ, tissue, or corneal transplant?	☐	☐
29. Been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?	☐	☐
30. Been treated with Human Pituitary Growth Hormone or other Human Pituitary Extract?	☐	☐
31. Been treated with Tigason or Neotigason (e.g. for Psoriasis or Acne)?	☐	☐
32. Taken care of or handled monkeys or their body fluids?	☐	☐
33. Been told that you should never give blood?	☐	☐
34. Had any problems during or after giving blood or blood samples?	☐	☐

Travel History:	Yes	No
35. Were you born outside of Ireland?	☐	☐
36. Did you live outside of Ireland before you were 5 years old?	☐	☐
37. Have you been outside of Ireland or the UK in the past 12 months for any reason?	☐	☐
38. Have you EVER lived in a malarial area?	☐	☐
39. Have you EVER had Malaria, Chagas' Disease or Babesiosis?	☐	☐
40. Have you EVER had an unexplained fever?	☐	☐
41. Have you EVER lived in or visited Mexico, Central or South America for four weeks or more?	☐	☐
42. Was your mother born in Mexico, Central or South America?	☐	☐

If you are female:	Yes	No
43. Have you EVER been pregnant or are you pregnant at present?	☐	☐
44. Have you had Anti-D in Ireland between 1 May 1977 & 31 July 1979 or 1 March 1991 & 18 February 1994?	☐	☐
45. Have you EVER had treatment for infertility?	☐	☐

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

46. For all Donors:	Yes	No
• Are you giving blood JUST to be tested for HIV or hepatitis?	☐	☐
• Do you or your partner have HIV?	☐	☐
• 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.	☐	☐
• Have you EVER been given money or drugs for sex?	☐	☐
• IF YOU ARE MALE, have you EVER had oral or anal sex with another male - with or without a condom or other form of protection?	☐	☐

If the answer to any of the above is Yes or if you are in any doubt you must tick Yes and must NOT donate.

47. In the past 12 months, have you had:	Yes	No
• Sex with anyone who has HIV or hepatitis?	☐	☐
• Sex with anyone who has EVER been given money or drugs for sex?	☐	☐
• Sex with anyone who may EVER have had sex in parts of the world where HIV is very common? This includes Africa and South East Asia.	☐	☐
• Sex with anyone who has EVER injected or who has been injected with non-prescribed drugs, EVEN ONCE OR A LONG TIME AGO? This includes body-building drugs.	☐	☐
• Sex with anyone with Haemophilia or other blood clotting disorder who has EVER been treated with Clotting Factor Concentrates?	☐	☐
• IF YOU ARE FEMALE: Sex with a male who has EVER had oral or anal sex with another male, with or without a condom or other form of protection?	☐	☐

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

In the past 12 months have:	Yes	No
• You been imprisoned?	☐	☐
• You snorted Cocaine or any other Drug?	☐	☐

If the answer to any of the above is Yes, or if you are in any doubt you must tick Yes and must NOT donate for 12 months.

SAMPLE ONLY