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

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

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

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. Been in contact with anyone with an infectious disease?	☐	☐
6. Taken any tablets or medicines other than the pill or HRT for the menopause?	☐	☐
7. Had treatment with Proscar, Propecia, Roaccutane, Isotrex, Retin-A or Zorac?	☐	☐
8. Had treatment from a dentist?	☐	☐

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

In the past 3 months have you:	Yes	No
10. 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
11. Had acupuncture?	☐	☐
12. Had ear, face or body piercing?	☐	☐
13. Had a tattoo or cosmetic treatment that involved piercing the skin?	☐	☐
14. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth or onto broken skin?	☐	☐
15. Had an endoscopy (scope)?	☐	☐
16. Been in close contact with a person with hepatitis?	☐	☐

Have you EVER:	Yes	No
17. Had a blood transfusion - red cells, platelets or plasma?	☐	☐
18. Had or been treated for syphilis or gonorrhoea?	☐	☐

Since 01 January 1980 have you:	Yes	No
19. 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
20. Had any serious illness or medical condition?	☐	☐
21. Been treated by a Dermatologist or skin specialist?	☐	☐
22. Had an operation or any surgery?	☐	☐
23. Had jaundice or hepatitis?	☐	☐
24. Had a sexually transmitted infection?	☐	☐
25. Been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?	☐	☐
26. Taken care of or handled monkeys or their body fluids?	☐	☐

After your last donation did you:	Yes	No
27. Faint or have any problems?	☐	☐

Travel:	Yes	No
28. In the last 12 months OR since your last donation (if less than 12 months ago) have you been outside Ireland or the UK for any reason e.g. business or holidays?	☐	☐
29. Have you EVER had malaria or an unexplained fever or an illness which you could have picked up while travelling?	☐	☐
30. Have you EVER lived in a malarial area for 6 months or more?	☐	☐
31. Have you EVER lived in or visited Mexico, Central or South America for 4 weeks or more?	☐	☐

If you are female:	Yes	No
32. Have you EVER been pregnant or are you pregnant at present?	☐	☐
33. Have you received a donated egg or embryo since 01 January 1980?	☐	☐

34. For all donors:	Yes	No
• Are you donating 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?	☐	☐

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

36. In the past 12 months:	Yes	No
• Have you been imprisoned?	☐	☐
• Have you snorted Cocaine or any other drug?	☐	☐

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

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

Reg. Clerk Signature

	Y	N
RDI carried out?	☐	☐

Donor: Accepted ☐ Deferred ☐

RGN / ADA 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: .....