

**NHS Blood and Transplant (NHSBT)**

**Donor Agreement Form**

<b>Name</b>	<i>Please print</i>
<b>Address</b>	
<b>Date of birth</b>	
<b>Daytime contact telephone number</b>	

**How often do you want to donate?** *Please tick*

**Intervals**      **Less than 12 weeks**     **12 weeks or more**   
*(minimum of 6 weeks)*

I understand that NHS Blood and Transplant (NHSBT) collects blood for the benefit of patients.

I confirm that my haemochromatosis will continue to be the responsibility of my managing doctor.

I understand that in the event I am unable to donate blood regularly for whatever reason, then I will need to inform the doctor who manages my haemochromatosis.

I wish to become an NHSBT blood donor.

**Signed** .....

**Date** .....

**PLEASE COMPLETE AND PROVIDE INFORMATION ON DOCTOR WHO MANAGES YOUR HAEMOCHROMATOSIS CONDITION OVERLEAF**

**Medical Information**

The doctor below has confirmed the following:

- Genetic haemochromatosis, homozygous C282Y or double heterozygote
- Completion of intensive venesection (if required) with ferritin in or close to the normal range
- The absence of associated complications including cardiac or hepatic impairment
- Not receiving chelation treatment currently
- Without a serious adverse reaction to venesection in the past

**Date of last venesection**.....

**Date & value of Last Ferritin** .....

**Email or Telephone contact**.....

**Hospital No**.....

**Specialist/ Clinician in charge**.....

**Hospital** .....

Please provide details of your GP:

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**Thank you for your cooperation**  
(Please return the form in the reply-paid envelope)

**PLEASE RETURN FORM TO:** Name: .....

Address: .....

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