

Donation Safety Check for Regular Donors

The following questions must be completed by all potential blood donors. We realise that some questions may appear intrusive, but your answers will be treated with absolute confidentiality. Please answer all questions to the best of your knowledge to ensure your own safety and that of any potential recipient of your donation. If you are uncertain of any answer or answer 'Yes' to any question, please call the donor helpline on 0300 123 23 23 or visit www.blood.co.uk to check if you are eligible to donate. Please use blue or black ballpoint pen to complete this form.

No	Question	DT CODE	Yes	No	Staff
1	Have you ever had sex with anyone with Human T Cell Lymphotropic Virus (HTLV) or anyone who has ever had viral haemorrhagic fever (including Ebola)?		<input type="checkbox"/>	<input type="checkbox"/>	
2	In the last 7 days have you seen a doctor, dentist, dental hygienist or any other healthcare professional or are you waiting to see one?		<input type="checkbox"/>	<input type="checkbox"/>	
3	In the last 7 days have you taken any aspirin, painkillers, anti-inflammatories, or taken any other medicines or tablets that you have bought yourself?		<input type="checkbox"/>	<input type="checkbox"/>	
4	In the last 2 weeks have you had any illness, infection or fever, or do you think you have one now?		<input type="checkbox"/>	<input type="checkbox"/>	
5	In the last 4 weeks have you been in contact with anyone with an infectious disease?		<input type="checkbox"/>	<input type="checkbox"/>	
6	In the last 8 weeks have you had any immunisations, vaccinations or jabs (including smallpox)?		<input type="checkbox"/>	<input type="checkbox"/>	
7	In the last 8 weeks have you been in contact with anyone who has had a smallpox vaccination?		<input type="checkbox"/>	<input type="checkbox"/>	
	In the last 3 months have you...	DT CODE	Yes	No	Staff
8	...used drugs during sex (excluding erectile dysfunction drugs or cannabis)?		<input type="checkbox"/>	<input type="checkbox"/>	
9a	...had sex with a new partner, or more than one partner?		<input type="checkbox"/>	<input type="checkbox"/>	
9b	If 'Yes' did you have anal sex?		<input type="checkbox"/>	<input type="checkbox"/>	
10	...taken Pre-Exposure Prophylaxis (PrEP) / Truvada for prevention of HIV, or have you taken or been prescribed Post-Exposure Prophylaxis (PEP) for prevention of HIV?		<input type="checkbox"/>	<input type="checkbox"/>	
11	...been given money or drugs for sex?		<input type="checkbox"/>	<input type="checkbox"/>	
12	...had sex with anyone with gonorrhoea, hepatitis, syphilis or anyone who is HIV positive?	C	<input type="checkbox"/>	<input type="checkbox"/>	
13	...had sex with anyone who has ever been given money or drugs for sex?		<input type="checkbox"/>	<input type="checkbox"/>	
14	...had sex with anyone who has ever injected drugs?		<input type="checkbox"/>	<input type="checkbox"/>	
	Since your last donation have you...	DT CODE	Yes	No	Staff
15	...been told that you should no longer give blood?		<input type="checkbox"/>	<input type="checkbox"/>	
16	...had hepatitis, jaundice or think you may have hepatitis now?	J	<input type="checkbox"/>	<input type="checkbox"/>	
17	...shared a home with a person with hepatitis?	C	<input type="checkbox"/>	<input type="checkbox"/>	
18	...injected yourself, or been injected with, illegal or non-prescribed drugs, including body-building drugs or cosmetics or injectable tanning agents?		<input type="checkbox"/>	<input type="checkbox"/>	
19	...tested positive for HIV, syphilis, or gonorrhoea?		<input type="checkbox"/>	<input type="checkbox"/>	
20	...seen a doctor with any complaints about your heart, or had any other serious illness?		<input type="checkbox"/>	<input type="checkbox"/>	
21	...had any medical investigations, tests, operations or alternative therapies?	S/E	<input type="checkbox"/>	<input type="checkbox"/>	
22	...had any addition or change to your prescribed medicines, tablets or therapy (except HRT, the pill or other birth control)? Tick "No" if not applicable		<input type="checkbox"/>	<input type="checkbox"/>	
23	...had your ears, face or body pierced, had a tattoo or any cosmetic treatment that involved piercing your skin?	S	<input type="checkbox"/>	<input type="checkbox"/>	
24	...had acupuncture?	S	<input type="checkbox"/>	<input type="checkbox"/>	
25	...been exposed to someone else's blood or body fluids, e.g. through a needle prick or bite or broken skin?	S	<input type="checkbox"/>	<input type="checkbox"/>	
26	...had a blood or blood product transfusion?		<input type="checkbox"/>	<input type="checkbox"/>	
27	...or anyone in your family been diagnosed with Creutzfeldt-Jakob Disease (CJD)?		<input type="checkbox"/>	<input type="checkbox"/>	
	Travel – Since your last donation...	DT CODE	Yes	No	Staff
28	...have you been outside the UK (including business trips)? If 'Yes' please answer 29, 30 and 31. If 'No' ignore the following questions 29, 30 and 31 (<i>staff must also check previous long stay or malaria</i>)	R L/V	<input type="checkbox"/>	<input type="checkbox"/>	
29a	...have you lived or stayed outside the UK for a continuous period of 6 months or more?	L	<input type="checkbox"/>	<input type="checkbox"/>	
29b	If 'Yes' have you been outside the UK since you returned?	L	<input type="checkbox"/>	<input type="checkbox"/>	
30	...have you visited Central America, South America or Mexico for a continuous period of 4 weeks or more?	R	<input type="checkbox"/>	<input type="checkbox"/>	
31a	...have you had malaria or an unexplained fever which you could have picked up while travelling or living or working abroad?	M/F	<input type="checkbox"/>	<input type="checkbox"/>	
31b	If 'Yes' have you been outside the UK since then?	V	<input type="checkbox"/>	<input type="checkbox"/>	

Donor Details (IN CAPITAL LETTERS)	STAFF USE ONLY. Please use a continuation sheet if required.	CLINICAL NOTES
Forename Surname Signature Date /..... /.....	Withdraw/suspend until /..... /..... <input type="checkbox"/> Set Medical Bar <input type="checkbox"/> Attention Clinical Support Team <input type="checkbox"/> Medical Referral <input type="checkbox"/> Additional notes	<input type="checkbox"/> Withdraw <input type="checkbox"/> Accept <input type="checkbox"/> Suspend until /..... /..... CST/Donor Records Signature..... Date /..... /.....

Surname
Forenames

Group

Title

DOB

Donor No

Address

Tel No

Procedure

Tel No. (day)

01 Donated Outcome of Attendance
02 Low Hb
03 Other samples only
04 No Donation – No numbers
05 No Donation – Numbers issued
06 No Donation – Pack labelled

Donation No

Code

PACK HOLD CODE

Signature

BBMR

Total

Attendance

Outcome

Award

Date

Panel

Sub Panel

P:
T:

DONATION TYPE:

Whole Blood Apheresis Autologous Tears

I have completed my tasks in accordance with SOPs

Signatures

Incident Record

Registration

Pre-Donation Screening

Hb Pass Fail

Session Hb resultg/L

Machine / Pack set up

CD second check

Venepuncture

Needle Removal

Dressing / PD advice

Final Pack / Sample Check

Reconciliation

HBV (AC)

S DD MM YY

J DD MM YY

C DD MM YY

E DD MM YY

Arm used:

L R

Needle adjusted:

Y N

Signature.....

T-Cruzi (TC)

R DD MM YY

L DD MM YY

Vein used:

M C B

Uneventful

donation:

Y N

Malaria (MA)

R DD MM YY

L DD MM YY

T DD MM YY

M DD MM YY

V DD MM YY

F DD MM YY

West Nile Virus (WNV)

R DD MM YY

F DD MM YY

W DD MM YY

Donor Consent – to be signed in the presence of a member of NHSBT staff

- I have read and understood the additional information provided to me today about giving blood and blood components. I understand the donation process and the risks outlined in the consent information. I understand that, despite mitigating measures, some of these risks may still occur. I have had the opportunity to ask questions and these have been answered to my satisfaction.
- I agree that my donation will be tested for the infections listed in the consent information and that there may be additional tests on my blood done, either because of information I have provided (e.g. travel history) or to meet the special needs of certain patients (e.g. babies). I understand that a sample of my blood will be kept for three years, and in certain situations, NHSBT may test my blood again in the future if a new test comes along. I understand that if my donation gives a positive result for any of the microbiological tests, I will be contacted, and the results will be discussed with me.
- I give my blood to NHS Blood and Transplant and I understand that it is intended for transfusion to patients, unless unsuitable or required for an

alternative purpose. Such alternative purposes can include research and development, education and training, quality assurance or making products for the diagnosis, testing, prevention, and treatment of disease.

- I understand that there are several reasons, either due to test results or any significant complication, when I will not be able to continue donating blood or blood products. I will be informed by NHSBT and will be able to discuss this if I wish.
- I understand that my information and any test results will be kept on record for a minimum of 30 years to ensure the safety of patients and the traceability of donations. This is in accordance with the Data Protection Act 2018, the Blood Safety Quality Regulations 2005 and the General Data Protection Regulation (GDPR).
- I understand that failing to answer any question as fully as possible and to the best of my knowledge, could lead to possible harm to me as a donor, and/or an unsafe donation which could potentially cause patient harm or death.

Donor Signature

Date

DD MM YY