

# Donation Safety Check for New and Returning 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](http://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	Are you taking any <b>prescribed</b> medicines or tablets or other treatments (except HRT, the pill or other birth control)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you ever tested positive for HIV, or do you think you may be HIV positive?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	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"/>	<input type="checkbox"/>
4	Have you ever had jaundice or hepatitis, or do you think you may have hepatitis now?	J	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Have you ever injected yourself, or been injected with, illegal or non-prescribed drugs, including body-building drugs or cosmetics or injectable tanning agents (even if this was only once or a long time ago)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you ever had or been treated for syphilis or gonorrhoea?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Have you ever been told that you should not give blood?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Have you ever seen a doctor with any complaints about your heart, or had any other serious illness?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Have you <b>ever</b> had any medical investigations, tests, operations or alternative therapies?	S/E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Have you ever received a blood or blood product transfusion?	T/R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Have you or anyone in your family had Creutzfeldt-Jakob Disease (CJD)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Were you treated with growth hormone before 1985?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Did you have brain surgery or an operation for a tumour or cyst in your spine before August 1992?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Have you had fertility treatment, or had IVF for any other reason since 1980?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	<b>In the last 7 days</b> 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"/>	<input type="checkbox"/>
16	<b>In the last 7 days</b> 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"/>	<input type="checkbox"/>
17	<b>In the last 2 weeks</b> have you had any illness, infection or fever, or do you think you have one now?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	<b>In the last 4 weeks</b> have you been in contact with anyone with an infectious disease?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	<b>In the last 8 weeks</b> have you had any immunisations, vaccinations or jabs (including smallpox)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	<b>In the last 8 weeks</b> have you been in contact with anyone who has had a smallpox vaccination?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>In the last 3 months have you...</b>	DT CODE	Yes	No	Staff
21	...had sex with anyone who has had syphilis, gonorrhoea, hepatitis, or anyone who is HIV positive?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	...been given money or drugs for sex?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	...had sex with anyone who has ever been given money or drugs for sex?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	...had sex with anyone who has ever injected drugs?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	...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"/>	<input type="checkbox"/>
26	...used drugs during sex (excluding erectile dysfunction drugs or cannabis)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27a	...had sex with a new partner, or had sex with more than one partner?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27b	<b>If 'Yes'</b> did you have anal sex?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>In the last 12 months have you...</b>	DT CODE	Yes	No	Staff
28	...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"/>	<input type="checkbox"/>
29	...had acupuncture?	S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	...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"/>	<input type="checkbox"/>
31	...shared a home with a person with hepatitis?	C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	...had sex with anyone with hepatitis?	C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Travel</b>	DT CODE	Yes	No	Staff
33	<b>In the last 12 months</b> have you been outside the UK (including business trips)?	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34a	Were you born or have you ever lived or stayed outside the UK for a continuous period of 6 months or more?	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34b	<b>If 'Yes'</b> have you been outside the UK since then?	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35a	Have you ever 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"/>	<input type="checkbox"/>
35b	<b>If 'Yes'</b> have you been outside the UK since then?	V	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36	Have you ever visited Central America, South America or Mexico for a continuous period of 4 weeks or more?	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37	Were you or your mother born in Central America, South America or Mexico?	L	<input type="checkbox"/>	<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	Group	
Forenames		
Title	DOB	Donor No

Address	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
Tel No		Code
Procedure		
Tel No. (day)	PACK HOLD CODE <input type="text"/> Signature .....	BBMR

Total Award	Attendance	Outcome	Date
			Panel
			Sub Panel

P: T:	
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DONATION TYPE:	Whole Blood <input type="checkbox"/>	Apheresis <input type="checkbox"/>	Autologous Tears <input type="checkbox"/>
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I have completed my tasks in accordance with SOPs	Signatures	Incident Record		
Registration		<b>HBV (AC)</b>	<b>T-Cruzi (TC)</b>	<b>Malaria (MA)</b>
Pre-Donation Screening		S DD MM YY	R DD MM YY	R DD MM YY
Hb Pass <input type="checkbox"/> Fail <input type="checkbox"/>		J DD MM YY	L DD MM YY	L DD MM YY
Session Hb result .....g/L		C DD MM YY	<b>West Nile Virus (WNV)</b>	T DD MM YY
Machine/Pack set up		E DD MM YY	R DD MM YY	M DD MM YY
CD second check			F DD MM YY	V DD MM YY
Venepuncture		<b>Vein used:</b>	W DD MM YY	F DD MM YY
Needle Removal		M <input type="checkbox"/>	<b>Needle adjusted:</b>	
Dressing/PD advice		C <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Ethnic Code</b> <input type="checkbox"/>
Final Pack/Sample Check		B <input type="checkbox"/>	Signature .....	
Reconciliation		<b>Arm used:</b>	<b>Uneventful donation:</b>	<b>Sickle Test</b> Y <input type="checkbox"/>
		L <input type="checkbox"/> R <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

**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