
Annex 2

Example of a blood donor questionnaire

BLOOD TRANSFUSION SERVICE		
DONOR QUESTIONNAIRE		
Please complete this form		
Panel name: _____	Donor no: _____	
Family name: _____	First name: _____	
Title: _____	ID No: _____	
Date of birth: _____	Gender: _____	
Occupation: _____		
Residential address: _____		
Postal address: _____		
Telephone no. Home: _____	Work: _____	Mobile: _____
E-mail address: _____		
1 HEALTH ASSESSMENT		
Please tick the appropriate answer to each question		
	Yes	No
1.1 Are you feeling well and in good health today?	<input type="checkbox"/>	<input type="checkbox"/>
1.2 in the last 4 hours, have you had a meal or snack?	<input type="checkbox"/>	<input type="checkbox"/>
1.3 Have you already given blood in the last 16 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
1.4 Have you got a chesty cough, sore throat or active cold sore?	<input type="checkbox"/>	<input type="checkbox"/>
1.5 Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
1.6 Do you have or have you ever had:		
a Chest pains, heart disease/surgery or a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
b Lung disease, tuberculosis or asthma?	<input type="checkbox"/>	<input type="checkbox"/>
c Cancer, a blood disease, an abnormal bleeding disorder, or a bleeding gastric ulcer or duodenal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
	d Diabetes, thyroid disease, kidney disease, epilepsy (fits)?	<input type="checkbox"/>	<input type="checkbox"/>
	e Chagas disease, babesiosis, HTLVI/II or any other chronic infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
1.7	In the last 7 days, have you seen a doctor, dentist or any other healthcare professional or are you waiting to see one (except for routine screening appointments)?	<input type="checkbox"/>	<input type="checkbox"/>
1.8	In the past 12 months:		
	a Have you been ill, received any treatment or taken any medication?	<input type="checkbox"/>	<input type="checkbox"/>
	b Have you been under a doctor's care, undergone surgery, or a diagnostic procedure, suffered a major illness, or been involved in a serious accident?	<input type="checkbox"/>	<input type="checkbox"/>
1.9	Have you ever had yellow jaundice (excluding jaundice at birth), hepatitis or liver disease or a positive test for hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
	a In the past 12 months, have you had close contact with a person with yellow jaundice or viral hepatitis, or have you been given a hepatitis B vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
	b Have you ever had hepatitis B or hepatitis C or think you may have hepatitis now?	<input type="checkbox"/>	<input type="checkbox"/>
	c In the past 12 months, have you been tattooed, had ear or body piercing, acupuncture, circumcision or scarification, cosmetic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
1.10	In the past 12 months, have you or your sexual partner received a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
1.11	Have you or your sexual partner been treated with human or animal blood products or clotting factors?	<input type="checkbox"/>	<input type="checkbox"/>
1.12	Have you ever had injections of human pituitary growth hormone, pituitary gonadotrophin (fertility medicine) or seen a neurosurgeon or neurologist?	<input type="checkbox"/>	<input type="checkbox"/>
1.13	Have you or close relatives had an unexplained neurological condition or been diagnosed with Creutzfeldt-Jacob Disease or 'mad cow disease'?	<input type="checkbox"/>	<input type="checkbox"/>
1.14	Have you:		
	a Ever had malaria or an unexplained fever associated with travel?	<input type="checkbox"/>	<input type="checkbox"/>
	b Visited any malarial area in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
1.15	When did you last travel to another region or _____ country (in months / years)?		

2 RISK ASSESSMENT

		Yes	No
2.1	Is your reason for donating blood to undergo an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>
2.2	Have you ever been tested for HIV?	<input type="checkbox"/>	<input type="checkbox"/>
2.3	If "Yes" what was the reason? <input type="checkbox"/> Voluntary <input type="checkbox"/> Employment <input type="checkbox"/> Insurance <input type="checkbox"/> Medical advice Other: _____		
2.4	Have you ever had casual, oral or anal sex with someone whose background you do not know, with or without a condom?	<input type="checkbox"/>	<input type="checkbox"/>
2.5	Have you ever exchanged money, drugs, goods or favours in return for sex?	<input type="checkbox"/>	<input type="checkbox"/>
2.6	Have you suffered from a sexually transmitted disease (STD): e.g. syphilis, gonorrhoea, genital herpes, genital ulcer, VD, or 'drop'?	<input type="checkbox"/>	<input type="checkbox"/>
2.7	In the past 12 months:		
	a Has there been any change in your marital status?	<input type="checkbox"/>	<input type="checkbox"/>
	b If sexually active, do you think any of the above questions (2.1–2.6) may be true for your sexual partner?	<input type="checkbox"/>	<input type="checkbox"/>
	c Have you been a victim of sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>
2.8	Have you or your sexual partner suffered from night sweats, unintentional weight loss, diarrhea or swollen glands?	<input type="checkbox"/>	<input type="checkbox"/>
2.9	Have you ever injected yourself or been injected with illegal or non-prescribed drugs including body-building drugs or cosmetics (even if this was only once or a long time ago)?	<input type="checkbox"/>	<input type="checkbox"/>
2.10	Have you been in contact with anyone with an infectious disease or in the last 12 months have you had any immunizations, vaccinations or jabs?	<input type="checkbox"/>	<input type="checkbox"/>
2.11	Have you ever been refused as a blood donor, or told not to donate blood?	<input type="checkbox"/>	<input type="checkbox"/>

3 DECLARATION

Please do not sign until you have answered all the questions and read the declaration below.

- a I confirm that, to the best of my knowledge, I have answered all the questions accurately and I consider my blood safe for transfusion to a patient.

- b I understand that any wilful misrepresentation of facts could endanger my health or that of patients receiving my blood and may lead to litigation. I am aware that my blood will be screened for, among others, HIV, hepatitis B, hepatitis C and syphilis. I understand that these screening tests are not diagnostic and may yield false-positive results. If any of the tests give a reactive result, I will be contacted using the information I have provided, and offered counselling.
- c I understand the blood donation process, and I have been counseled regarding the importance of safe blood donation.
- d I confirm that I am over the age of 18 years.
- e I undertake that should there be any reason for my blood to be deemed unsafe for use at any stage, I will inform the Blood Transfusion Service.

Donor's signature: _____

Decision: Accept Defer

Donor weight : _____ kg

Blood pressure: _____ Haemoglobin/haematocrit: _____

Deferral period: _____

Reason for deferral: _____

Interviewed by (name and signature): _____

Venepuncture performed by (name and signature): _____

Date: _____