ରକ୍ତଦାନ, ଜୀବନ ଦାନ

"DONATE BLOOD, SAVE LIFE"

Blood Donor Questionnaire & Consent Form

License No.:	Blood Unit No.:

CONFIDENTIAL

[✓] Tick wherever applicable

Pl. answers the following questions correctly. This will help to protect you and the patient who receives your blood.

Name:	Male:	Female:
Date of Birth: Age:	Father's Name:	
Occupation:	Organization:	

Address for communication:

Telephone:	Mobile No.:
Would you like us to call you on your mobile: ☐ Yes ☐ No	
Fax No.	E-mail:
Have you donated previously: ☐ Yes ☐ No If yeas, how many occasions:	When last:
Your blood group:	Time of last meal:
Did you have any discomfort during/after donation? ☐ Yes ☐ No	

[ ] Tick the appropriate answer:

1. Do you feel well today?	Yes	No
2. Did you have something to eat in the last 4 hours?	Yes	No
3. Did you sleep well last night?	Yes	No

4. Have you any reason to believe that you may be infected By either Hepatitis, Malaria, HIV/AIDS, and/or venereal disease? Yes No

5. In the last 6 months have you had any history of the following:-
   - ☐ Unexplained weight loss
   - ☐ Repeated Dirrhoea
   - ☐ Swollen glands
   - ☐ Continuous low-grade fever

6. In the last 6 month have you had any:-
   - ☐ Tattooing
   - ☐ Ear Piercing
   - ☐ Dental Extraction

7. Do you suffer from or have suffered from any of the following diseases?
   - ☐ Heart Disease
   - ☐ Cancer/ Malignant Disease
   - ☐ Diabetes
   - ☐ Abnormal bleeding tendency
   - ☐ Allergic Disease
   - ☐ Sexually Trans. Diseases
   - ☐ Typhoid (last 1 yr.)
   - ☐ Lung Disease
   - ☐ Epilepsy
   - ☐ Tuberculosis
   - ☐ Hepatitis B/C
   - ☐ Jaundice (last 1 yr.)
   - ☐ Malaria (6 months)
   - ☐ Fainting Spells)
   - ☐ Kidney Disease

Are you taking or have taken any of these in the past 72 hours.

- ☐ Antibiotics
- ☐ Steroids
- ☐ Dog Bite/Rabies Vaccine (1 yr.)
- ☐ Aspirin
- ☐ Vaccinations
- ☐ Alcohol

8. Is there any history of surgery or blood transfusion in the past 6 months?
   ☐ Major ☐ Minor ☐ Blood Transfusion

9. For women donors,
   Are you pregnant ☐ Yes ☐ No
   Have you had an abortion in the last 3 months ☐ Yes ☐ No
   Do you have a child less then one year old? ☐ Yes ☐ No

10. Would you like to be informed about any abnormal test result at the address furnished by you?
☐ Yes ☐ No

Have you read and under understood all the information represented and answered all the questions truthfully, as any incorrect statement or concealment may affect your health or may harm the recipient?
☐ Yes ☐ No

I understand that

(a) blood donation is a totally voluntary act and no inducement or remuneration has been offered.

(b) donation of blood/ components is a medical procedure and that by donating voluntarily, I accept the risks associated with this procedure.

© my blood will be tested for Hepatitis B, Hepatitis-C, malaria Parasite, HIV/AIDs and veneral diseases in addition to any other screening tests required to ensure blood safety.

I prohibit any information provided by me or about my donation to be disclosed to any individual or government agency without my prior permission.

Date:_____ Time:_____ Donor's Signature_____

General Physical Examination:

Weight _____ Pulse _____Hb_____

BP_____ Temperature _____

☐ Accept ☐ Defer Reason_____

Signature of Medical Officer:_____

Blood safety begins with a Healthy Donor