BLOOD DONOR REGISTRATION FORM

FILLED BY DONOR

Donor' s code ..... Date: _____

Last and first name: _____ Parent's name: _____

Passport №: _____ Date of birth: _____ Sex: M F

Home adress: _____ Municipality: _____

City: _____ Home phone: _____ Office phone: _____ Cell phone: _____

Currently employed at: _____ Occupation _____

Number of previous donations: _____ Signature: _____

FILLED BY PROFESSIONAL

Blood donor registration Bar code:

Blood type: _____

Physician's comment: _____

_____ Professional' s signature: _____

Hemoglobin/Hematocrit **Test plate blood group determination**

Copper sulphate test _____ Normal level _____ Low level _____ **A B AB O**

Hemoglobinometer _____ Value _____ Technician's signature: _____

Physical exam Accept

Lungs _____ Heart _____ B _____/_____ Defer

Weight _____ Height _____ Reason _____

Blood bag type _____ _____

Comment: _____ Medical doctor's signature: _____

Blood bag preparation **Lot number**

Technician's signature: _____

Venepunction - left hand - right hand Start: _____ hrs _____ min

Quantity of collected blood: 405-495 ml <405 ml >495 ml Finish: _____ hrs _____ min

Reason of blood collection interruption: _____

Signed and sealed by medical doctor Technician's signature

_____ _____

DONOR QUESTIONNAIRE

Please read the questionnaire and answer truthfully to each question. Questionnaire is important for your health protection and safety of transfuzed patients. Your answers and personal data will be confidential and will be used only for the requirements of the authorized blood establishment

1.	Have vou ever donated blood or blood compaments?	YES	NO
2.	Have you ever been rejected to donate blood or blood components?	YES	NO
3.	Are you feeling healthy, capable and rested to donate blood today?	YES	NO
4.	Have you had something to eat before blood or blood component donation?	YES	NO
5.	Do you have a hazardous occupation or dannerous hobby?	YES	NO
6.	Are you currently or regulary taking any medications?	YES	NO
7.	Are you currently taking analgetics or pain killers or did you take them in the past 2-3 days?	YES	NO
8.	Are you currently taking Aspirin or Cardiopirin or did you take them in the past 5 days?	YES	NO
9.	Have you ever been hospitalized for medical investigation or treatment? Are you currently on sick leave or undergoing medical investigation?	YES	NO
10.	Have you had tooth extraction recently?	YES	NO
11.	Have you had cold or any other respiratory Infection in the past 7-10 days or had to take antibiotics?	YES	NO
12.	Have you had vaccination in the previous 12 months?	YES	NO
13.	Did you have extreme weight loss in the past 6 months?	YES	NO
14.	Have you had a tick bite requiring professional help?	YES	NO
15.	Have you ever been treated for epilepsy, diabetes, asthma, tuberculosis, Infarct, stroke, cancer, mental illnesses or malaria?	YES	NO
16.	Do you have some chronical diseases of heart, lungs, kidneys, liver, stomach and intestines, joints, muscles, nervous system, blood or blood vessels?	YES	NO
17.	Have vou ever had problems with thyroid or pituitary qlands and/or received hormone therapy?	YES	NO
18.	Do you have skin alterations or any allerqies?	YES	NO
19.	Do you bleed or bruise easily?	YES	NO
20.	**In the past six months:**		
	a) Have you had surgery or received blood transfusion?	YES	NO
	b) Have you lived or traveled outside of Serbia?	YES	NO
	c) Have vou had acupuncture body/ear piercing or tatooing?	YES	NO
21.	Did you consume alcoholic drinks in the past six hours?		
22.	**Forms of risk conditions and behaviour:**		
	a) Have you ever had hepatitis A, B or C?	YES	NO
	b) Have you been in contact or do you live with the person having hepatitis?	YES	NO
	c) Do you think that you could have been infected with HIV?	YES	NO
	d) Have you ever used any kind of drugs?	YES	NO
	e) Have you ever used products issued without authorised prescription and/or body building products (steroids)?	YES	NO
	f) Have you ever taken money or drugs for sexual services?	YES	NO
	g) Are you aware of all possible ways of behaviour that could expose you to the risk of infectious, blood transmitted diseases?	YES	NO
23.	**Within past six months did you have unprotected sexual contacts:**		
	a) with an HIV positive person?	YES	NO
	b) with a person who has or has had hepatitis B or C?	YES	NO
	c) with a person who ever took money or drugs for sexual services?	YES	NO
	d) with a person who ever used any kind of drugs?	YES	NO
	e) with a person whose sexual behaviour could expose you to the risk of getting sexually transmitted diseases?	YES	NO
	f) did you have anal sexual intercourses within past six months?	YES	NO
	Questions for female donor		
24.	Are you pregnant?	YES	NO
25.	Do you have period at the moment?	YES	NO
26.	Did you have abortion or miscarriagie or delivery in the past 6 months?	YES	NO

BLOOD/BLOOD COMPONENT DONOR CONSENT

I filled donor questionnaire and I agree to donate blood/blood component and I declare that:

1. I read and understood educational material that i received and i declare responsibly that I answered truthfully to all questions and gave correct data.
2) I was informed that my blood will be tested to blood transmitted diseases.
3) I was informed of the possibility to give up on blood/blood component donation before the beginning of the procedure, as well as of the possibility to refuse to donate, i.e. of the possibility to wiithdraw consent during any instant of blood donation.
4) I was informed about the purpose of blood/blood component donation.
5) I was informed of the risks and possible reactions during blood donation and off all blood tests that will be performed.
6) I was informed about the protection and confidentiality of personal data.
7) I was offered possibility to ask questions.
8) I received satisfactory answers to all my questions.
9) According to my knowledge I provided correct information and
10) I confirm credibility of given data.

THANK YOU FOR DONATED BLOOD

_____
(Blood/blood component donor signature)

Note
- Gave up
- Refused to donate
- Consent withdrawal

Blood/blood component donor signature _____