Donor Health Check for new and returning donors

Please answer the following questions in blue or black ballpoint pen. If you are uncertain of any answer, leave the box blank and speak in confidence to the nurse. Please do not use correction fluid if you make a mistake on this form.

A Your lifestyle

		Yes	No	Staff
A1	Have you tested positive for HIV or do you think you may be HIV positive?			
A2	Have you ever had hepatitis B or hepatitis C or think you may have hepatitis now?			
A3	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)?			
A4	Have you ever been given money or drugs for sex?			
A5	**In the last 12 months have you had sex with:**			
a	anyone who is HIV positive;			
b	anyone with hepatitis B, hepatitis C or HTLV;			
c	anyone who has ever been given money or drugs for sex;			
d	anyone who has ever injected drugs; or			
e	anyone who may ever have had sex in parts of the world where AIDS/HIV is very common (this includes most countries in Africa)?			
A6	**Male donors only;** In the last 12 months have you had oral or anal sex with a man, with or without a condom?			
A7	**Female donors only;** In the last 12 months have you had sex with a man who has ever had oral or anal sex with another man, with or without a condom?			

B Your health

		Yes	No	Staff
B1	Have you ever been told that you should not give blood?			
B2	Have you ever had a serious illness or seen a doctor about your heart?			
B3	Have you ever had any hospital investigations or tests or operations?			
B4	Are you taking any prescribed medicine or tablets or other treatments (except HRT for the menopause, the pill or other birth control)?			
B5	**In the last 7 days** have you taken any **additional** medicines or tablets including any you have bought yourself?			
B6	**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)?			

Change of details – If we have your details wrong, please give us the correct information below.

Title.....Forename.....Surname.....

Address.....

Postcode.....Home no.....Work no.....

Mobile.....Email.....DoB: DD/MM/YYYY

C Risks of infection

		DT CODE	Yes	No	Staff
C1	**In the last 2 weeks** have you had any illness, infection or fever or do you think you have one now?				
C2	**In the last 4 weeks** have you been in contact with anyone with an infectious disease?				
C3	**In the last 8 weeks** have you had any immunisations, vaccinations or jabs?				
	In the last 12 months...				
C4	...have you had your ears, face or body pierced, had a tattoo or any cosmetic treatment that involved piercing your skin?	S			
C5	...have you had acupuncture?	S			
C6	...have you been exposed **unintentionally** to someone else's blood or body fluids eg through a needle prick or bite or broken skin?	S			
	Additional risks				
C7	Have you ever had jaundice or hepatitis?	J			
C8	Have you received a blood transfusion since 1st January 1980?				
C9	Has anyone in your family had CJD?				
C10	Were you treated with growth hormone before 1985?				
C11	Did you have brain surgery or an operation for a tumour or cyst in your spine before August 1992?				
C12	**Female donors only;** Have you ever had treatment for infertility?				

D Travel outside the UK

		DT CODE	Yes	No	Staff
D1	**In the last 12 months** have you been outside the UK (inc. business trips)?	R			
D2a.	Were you born or have you ever lived or stayed outside the UK for a continuous period of 6 months or more?	L			
b.	If 'yes' have you been outside the UK since then?	L			
D3a.	Have you ever had malaria or an unexplained fever which you could have picked up while travelling?	M/F			
b.	If 'yes' have you been outside the UK since then?	V			
D4	Have you ever visited Central America or South America for a continuous period of 4 weeks or more?	R			
D5	Were you or your mother born in Central America or South America?	L			

(IN CAPITALS) **Forename**.....(IN CAPITALS) **Surname**.....

Your Signature.....**Date**.....

STAFF USE ONLY

Withdraw/suspend until ...../...../.....

☐ Attention Clinical Support Team ☐ Medical Referal Form attached ☐ Set medical bar

CLINICAL NOTES

☐ Suspend until...../...../.....

☐ Withdraw

☐ Accept

Date...../...../.....

CST/Donor Records signature.....

Additional notes label ☐