<table>
<thead>
<tr>
<th>DONOR DETAILS &amp; ID CONFIRMED</th>
<th>DONOR STATUS</th>
<th>ABO / Rh</th>
<th>TYPE</th>
<th>VENUE CODE &amp; DETAILS</th>
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<tbody>
<tr>
<td>DONOR NUMBER</td>
<td>DONATION NUMBER 1</td>
<td>DONATION NUMBER 2</td>
<td>REGISTRATION DATE AND TIME</td>
<td>DONOR LINKED SIGNATURE</td>
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<tr>
<th>HB - Capillary</th>
<th>HB - Venous</th>
<th>Tx</th>
<th>NTx</th>
<th>Weight / Height</th>
<th>BP - 1</th>
<th>BP - 2</th>
<th>PULSE</th>
<th>PHLEBOTOMY TYPE</th>
<th>INTERVIEWER SIGNATURE</th>
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<tr>
<th>Phlebotomist Signature</th>
<th>TIME</th>
<th>DURATION</th>
<th>MIXER No</th>
<th>BARCODES REMOVED BY</th>
<th>ACTIVE DEFERRALS</th>
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<tbody>
<tr>
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<td>START</td>
<td>FINISH</td>
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<td>UNUSED</td>
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MEDICAL AND OTHER COMMENTS

LINKING DEFERRALS

LINKING COMMENTS

ADMINISTRATION AND DONOR MAINTENANCE

SIGNED DATE

SIGNED DATE

SIGNED DATE
1. You must **NEVER** give blood if:
   - You, or any of your sexual partners have (or had) AIDS or a positive test for HIV.
   - You carry the hepatitis B or C virus.
   - You have ever injected yourself, even once, with drugs not prescribed by a Doctor.
   - You have haemophilia or a related clotting disorder and have received treatment with plasma derived clotting factor concentrates at any time.
   - You think you need an HIV or hepatitis test.

**COULD ANY OF THE ABOVE APPLY TO YOU?** YES □ NO □

2. You must not give blood for 12 months:
   - Following oral or anal sex with or without a condom with another man (if you are male).
   - After engaging in sex work (prostitution) or accepting payment in exchange for sex.
   - After leaving a country in which you have lived and which is considered to be high risk of HIV infection (see map).

**COULD ANY OF THE ABOVE APPLY TO YOU?** YES □ NO □

3. You must not give blood for 12 months:
   - Following sex with anyone:
     - whom you know carries the hepatitis B or C virus.
     - who is a sex worker (prostitute).
     - who has ever injected themselves with drugs not prescribed by a Doctor.
     - who lives in or comes from a country considered high risk for HIV infection (see map).
   - who has haemophilia or a related blood clotting disorder and has received treatment with plasma derived clotting factor concentrates at any time.
   - If you are a woman, after engaging in sex with a man who has had oral or anal sex with another man.

**COULD ANY OF THE ABOVE APPLY TO YOU?** YES □ NO □

4. Did you have any injection of human pituitary extracts such as growth hormone or gonadotrophin (fertility treatment) before 1985? YES □ NO □

5. Do you suffer from an unexplained neurological condition or have you surgery of the brain or spinal cord? YES □ NO □

6. Have any of your blood relatives had CJD (Creutzfeldt-Jakob Disease)? YES □ NO □

7. Have you ever received a cell, tissue or organ transplant (cornea, kidney, bone-marrow, liver, etc)? YES □ NO □

8. Have you lived or travelled outside New Zealand or Australia in the last three years? YES □ NO □

9. Have you visited or lived in the United Kingdom (England, Scotland, Wales, Northern Ireland, Isle of Man and the Channel Islands) or in France or in the Republic of Ireland between 1st January 1980 and 31st December 1996 for a total period of 6 months or longer? YES □ NO □

10. Have you received a blood transfusion in the United Kingdom, France or the Republic of Ireland from 1980 onwards? YES □ NO □

11. Do you have any health concerns at present? YES □ NO □

12. Have you visited a Doctor/Health Clinic in the last 6 months or since your last donation? YES □ NO □

13. Have you taken any medicines at all in the last two weeks other than the contraceptive pill? YES □ NO □

14. In the last week have you had dental treatment, a cold sore, cold, cough, sore throat or any other infection? YES □ NO □

15. In the last 12 weeks have you or any of your household had any diarrhoea, vomiting, stomach pain or upset stomach? YES □ NO □

16. In the last 6 months have you had any of the following (please tick as appropriate):
   - Vaccinations
   - Needle stick injury
   - Acupuncture, body/ear piercing, tattooing
   - Any medical procedure e.g. endoscopy

**COULD ANY OF THE ABOVE APPLY TO YOU?** YES □ NO □

17. In the last year have you had any of the following (please tick as appropriate):
   - Hepatitis, jaundice
   - Surgical operation or blood transfusion

18. Women: Are you breast feeding or have you had a pregnancy, miscarriage or abortion in the last 12 months? YES □ NO □

19. In the last three years have you had treatment for acne or psoriasis? YES □ NO □

20. Have you ever had any of the following (please tick as appropriate):
   - Heart disorder
   - Stroke
   - Cancer
   - Epilepsy
   - Malaria
   - Severe allergy
   - Other serious illness

**COULD ANY OF THE ABOVE APPLY TO YOU?** YES □ NO □

21. Do you wear a medic-alert bracelet? YES □ NO □

22. Do you have a hazardous occupation or take part in a hazardous hobby e.g. flying, rock climbing? YES □ NO □

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Please read the Declaration below.

- Today I have read and understood the “Safe Blood Starts With You” leaflet and the “All About Donating Blood” leaflet.
- To the best of my knowledge my health information is correct. I am over the age of 16 years.
- I consent to my blood being tested for blood groups and evidence of some infections, including HIV, Hepatitis B & C, Syphilis, HTLV and any other test found necessary for the safety of the recipient. I understand I will be notified if any important abnormalities are found.
- In consenting to give blood, I understand it will be used for the benefit of others and may be used for transfusion, teaching, in diagnostic procedures and quality procedures. It may also be used in research but only when approved by a relevant Ethics Committee. Samples will be stored for future comparative tests and may need to be sent overseas for any special investigations.

Donor’s Signature: __________________ Date: ____________