NZBLOOD
Te Ratonga Toto O Aotearoa

DONOR SESSION RECORD

Appointment Time:	
Donation Count:	
Phlebotomy type:	

IF YOUR PERSONAL DETAILS ARE PRINTED BELOW: please check the information printed and write any corrections or updates. Please complete the questionnaire **and** read the declaration overleaf then sign when asked.

Title: MR / MRS / MISS / MS / Dr	First Names:	
Last Name:		Date of Birth: DD / MM / YYYY
Sex: MALE / FEMALE	Ethnic Groups:	Last Attendance:
Postal Address:		
Postcode:	Country of Birth:	
Email:		
Mobile:	Home Phone:	Work Phone:

STAFF USE ONLY

DONOR DETAILS & ID CONFIRMED	DONOR STATUS	ABO / Rh	TYPE	VENUE CODE & DETAILS

DONOR NUMBER	DONATION NUMBER 1	DONATION NUMBER 2	REGISTRATION DATE AND TIME	DONOR LINKED SIGNATURE

HB - Capillary	HB - Venous		Weight / Height	BP - 1	BP - 2	PULSE	PHLEBOTOMY TYPE	INTERVIEWER SIGNATURE
		Tx NTx	Weight Height			Reg / Irreg		

Phlebotomist Signature	TIME	DURATION	MIXER No	BARCODES	REMOVED BY	ACTIVE DEFERRALS
	START FINISH			USED UNUSED		

DO NOT PRINT

MEDICAL AND OTHER COMMENTS	SIGNED DATE
LINKING DEFERRALS	SIGNED DATE
LINKING COMMENTS	SIGNED DATE
ADMINISTRATION AND DONOR MAINTENANCE	SIGNED DATE

HEALTH QUESTIONS

THESE QUESTIONS MUST BE ANSWERED CAREFULLY. They protect you and any patients receiving your blood. A "Yes" answer **may not necessarily** exclude you from blood donation. **All donors must read the "Safe Blood Starts With You" and the "All About Donating Blood" leaflets.** Thank you very much for your help.

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 had 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 ☐

NZBS Use Only

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 YES ☐ NO ☐
- Needle stick injury YES ☐ NO ☐
- Acupuncture, body/ear piercing, tattooing YES ☐ NO ☐
- Any medical procedure e.g. endoscopy YES ☐ NO ☐

17. In the **last year** have you had any of the following (please tick as appropriate):

- Hepatitis, jaundice YES ☐ NO ☐
- Surgical operation or blood transfusion YES ☐ NO ☐

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 YES ☐ NO ☐
- Stroke YES ☐ NO ☐
- Cancer YES ☐ NO ☐
- Epilepsy YES ☐ NO ☐
- Malaria YES ☐ NO ☐
- Severe allergy YES ☐ NO ☐
- Other serious illness 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 ☐

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: _____

Privacy Act The information collected will be used and held by New Zealand Blood Service to assess your eligibility to donate blood and communicate with you in relation to your donation and the other services we provide. For more information about how we collect, use and store your information, please refer to our Privacy Statement which can be viewed at www.nzblood.co.nz. You have a right to access and request the correction of the information in accordance with the Health Information Privacy Code and related New Zealand law.