IDENTITY:

DONOR ID NUMBER :
FULL NAME :
FORMER SURNAME :
SEX, DATE OF BIRTH:
TITLE :
TOTAL DONATIONS :
PHONE NO. :
ADDRESS :

Donation Number

DATE :

DONOR SIGNATURE : .....

Donor Services Comments

	Y	N
Have You Ever Attended a Blood or Platelet Donor Clinic?	☐	☐
Have You Ever Donated?	☐	☐
Will you accept Text Messages from IBTS?	☐	☐
Will you accept Emails from IBTS?	☐	☐

Country Of Birth _____

Reg. Clerk Signature

EDI carried out? Y ☐ N ☐ Not Required ☐

Donor: Accepted ☐ Deferred ☐

Canteen Pre-Donation? Y ☐ N ☐

CNM / RGN Signature

Deferrals:

Deferral Code	Date From	Initials
		CNM / RGN

LAST DONATION:

Donation No. :

Date :
Phlebotomy :

TEST RESULTS: (Historical)

ABO/RH :
PAED USE :

CURRENT DONATION:

Donation Source :
Donation & Pack Type :

Cap. Hb _____ A/N _____ Sig _____ RGN ☐ DA ☐

Ven. Hb _____ A/N _____ Sig _____ RGN ☐ DA ☐

Comments:

VP 1 : Sig _____
L Arm ☐ R Arm ☐ RGN ☐ DA ☐
Discontinued: Yes ☐
Donation ☐ FBC ☐ S.O. ☐ ___

Adjusted: During VP ☐
Immediately Post VP ☐
During Donation ☐
RGN ☐ DA ☐

VP 2 : Sig _____
L Arm ☐ R Arm ☐ RGN ☐ DA ☐
Discontinued: Yes ☐
Donation ☐ FBC ☐ S.O. ☐ ___

Adjusted: During VP ☐
Immediately Post VP ☐
During Donation ☐
RGN ☐ DA ☐

Scales: | Agitator:
Timer: | Heatsealer:

Bedside: RGN ☐ DA ☐

Labelling: RGN ☐ DA ☐
Packs ☐ Initials _____
Pilot Tubes ☐ Initials _____

Start Time: | Stop Time:

Pack Batch No:

Needle 1 Removed: RGN ☐ DA ☐

Needle 2 Removed: RGN ☐ DA ☐

Pilot Tubes Check ☐ RGN ☐ DA ☐

Packs Label Check ☐ RGN ☐ DA ☐

Heatsealed by: RGN ☐ DA ☐

Linked By: RGN ☐ DA ☐

Comment Code: | Weight

TU Code: | W/M Alarmed ☐

Verification ☐ RGN ☐ DA ☐ DC ☐
Correction ☐ RGN ☐ DA ☐

DONOR DECLARATION

- Today, I read or listened to, understood and completed this Questionnaire. All the information I provided is true and accurate to the best of my knowledge.
- Today, I read or listened to and understood the Blood Safety and Blood Donation Information. To the best of my knowledge I am not at risk of the infections listed nor of transmitting these infections.
- I understand the nature of the donation process and the risks involved as described. I had an opportunity to ask questions and had satisfactory responses to any questions I asked. I consent to proceed with the donation process.
- I agree that my blood will be tested for HIV, hepatitis and other infectious agents and a small sample of blood will be stored. I understand that I will be notified of any results that may affect my health.
- I entrust my blood donation to the Irish Blood Transfusion Service to be used for the benefit of patients. This may be by direct transfusion to a patient, or indirectly as described.
- If I develop **any** illness after donating, I will **immediately** phone one of the Medical Staff in Dublin or Cork as this illness may have consequences for the patients who will receive my donation.
- I understand the IBTS will process information about me, my health, my attendances and my donations as explained in the donor information leaflets.
- I consent to the IBTS obtaining further details of illnesses or treatments from the Doctor/Hospital concerned if considered necessary to establish my eligibility to donate.

DONOR SIGNATURE: ..... IBTS STAFF SIGNATURE: .....

Please read carefully and tick ✓ Yes or No. If you are uncertain of any answer leave the box blank.

Donors 25 years or younger:	**Yes**
I would like to give a blood sample to join the **BONE MARROW** Registry.	
I have read the associated information leaflet.	☐

Are You:	**Yes**	**No**
1. Well and healthy at present?	☐	☐
2. Having any treatment from a doctor, dentist, nurse or any other health care professional?	☐	☐
3. Involved in a hazardous occupation or hobby?	☐	☐

Is Your:	**Yes**	**No**
4. Current gender different from that assigned to you at birth?	☐	☐

Have You:	**Yes**	**No**
5. Had any brain or spinal cord surgery in the UK* since 01 January 1980?	☐	☐
** UK includes Northern Ireland, England, Scotland, Wales, The Channel Islands & The Isle of Man*		

In the past 48 hours have you:	**Yes**	**No**
6. Taken an anti-inflammatory?	☐	☐

In the past 5 days have you:	**Yes**	**No**
7. Taken aspirin or any tablet with aspirin in it?	☐	☐

In the past 4 weeks have you:	**Yes**	**No**
8. Been in contact with an infectious disease?	☐	☐
9. Taken any tablets or medication other than the pill or HRT for the menopause?	☐	☐
10. Had treatment with Proscar, Propecia, Roaccutane, Isotrex, Retin-A or Zorac?	☐	☐
11. Had treatment from a dentist?	☐	☐

In the past 8 weeks have you:	**Yes**	**No**
12. Had a vaccination?	☐	☐

In the past 4 months have you:	**Yes**	**No**
13. Had acupuncture?	☐	☐
14. Had ear, face or body piercing?	☐	☐
15. Had a tattoo or cosmetic treatment that involved piercing the skin?	☐	☐
16. Had an endoscopy (scope)?	☐	☐
17. Been in close contact with a person with hepatitis or monkeypox?	☐	☐
18. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth or onto broken skin?	☐	☐

In the past 12 months have you:	**Yes**	**No**
19. Seen a doctor for any reason?	☐	☐
20. Had any medical tests or treatments?	☐	☐
21. Had an operation or any surgery?	☐	☐
22. Had monkeypox?	☐	☐

Your COMPLETE HONESTY in answering all questions is essential for your safety and the safety of patients who receive your blood. ALL INFORMATION YOU PROVIDE IS CONFIDENTIAL

23. Have you EVER had any of the following:

	Yes	No		Yes	No
Allergy/Asthma?	☐	☐	Epilepsy/Fits?	☐	☐
Cancer?	☐	☐	Fainted?	☐	☐
Diabetes?	☐	☐	Heart Condition?	☐	☐
Dizzy Spells?	☐	☐	Operation/Surgery?	☐	☐

Have you EVER:	**Yes**	**No**
24. Had any serious illness?	☐	☐
25. Had jaundice or hepatitis?	☐	☐
26. Received a blood transfusion?	☐	☐
27. Had a sexually transmitted infection?	☐	☐
28. Had or been treated for syphilis or gonorrhoea?	☐	☐
29. Had an organ, tissue, or corneal transplant?	☐	☐
30. Been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?	☐	☐
31. Been treated with Human Pituitary Growth Hormone or other Human Pituitary Extract?	☐	☐
32. Been treated with Tigason or Neotigason?	☐	☐
33. Taken care of or handled monkeys or their body fluids?	☐	☐
34. Been diagnosed with or treated for Haemochromatosis?	☐	☐
35. Had any problems during or after giving blood or blood samples?	☐	☐

Travel History:	**Yes**	**No**
36. Were you born outside of Ireland?	☐	☐
37. Did you live outside of Ireland before you were 5 years old?	☐	☐
38. Have you been outside of Ireland or the UK in the past 12 months for any reason?	☐	☐
39. Have you **EVER** lived in a malarial area?	☐	☐
40. Have you **EVER** had Malaria, Chagas' Disease or Babesiosis?	☐	☐
41. Have you **EVER** had an unexplained fever?	☐	☐
42. Have you **EVER** lived in or visited Mexico, Central or South America for four weeks or more?	☐	☐
43. Was your mother born in Mexico, Central or South America?	☐	☐

For Female donors and those who answered yes to Q4, Have you:	**Yes**	**No**
44. Been pregnant in the past 12 months or are you pregnant at present?	☐	☐
45. Had Anti-D in Ireland between 1 May 1977 & 31 July 1979 or 1 March 1991 & 18 February 1994?	☐	☐
46. **EVER** had treatment for infertility?	☐	☐

NEVER DONATE TO GET A TEST FOR HIV OR HEPATITIS
IF YOU DO YOU RISK INFECTING OTHER PEOPLE

47. For all Donors:	**Yes**	**No**
• Are you donating **JUST** to be tested for HIV or hepatitis?	☐	☐
• Do you or your partner have HIV or HTLV?	☐	☐
• Do you or your partner or close household contacts have hepatitis B or hepatitis C?	☐	☐
• Have you **EVER** injected or have you been injected with non-prescribed drugs - **EVEN ONCE OR A LONG TIME AGO?** This includes body building drugs & injectable tanning agents.	☐	☐
• Have you **EVER** been given money or drugs for sex?	☐	☐

48. In the past 4 months, have you had oral, vaginal or anal sex with:	**Yes**	**No**
• Anyone who has HIV, hepatitis B or C, or HTLV?	☐	☐
• Anyone who has syphilis or any other sexually transmitted infection?	☐	☐
• Anyone who has **EVER** been given money or drugs for sex?	☐	☐
• Anyone who has **EVER** injected drugs?	☐	☐

49. In the past 4 months have you had:	**Yes**	**No**
• A new sexual partner* **OR** more than one sexual partner?	☐	☐
IF YES: Did you have anal sex?	☐	☐

***A new sexual partner is someone you did not have sex with before, or a person with whom you resumed a sexual relationship in the past 4 months.**

All the above apply even if a condom or other form of protection was used.

50. In the past 4 months have you:	**Yes**	**No**
• Snorted cocaine or any other drug?	☐	☐
• Taken medication to prevent HIV infection (pre/post exposure prophylaxis, PrEP/PEP)?	☐	☐
• Taken part in Chemsex i.e. have you used drugs (other than cannabis, alcohol or Viagra) before or during sex to enhance sexual experience?	☐	☐
IF YES: Did you inject or were you injected with drugs?	☐	☐