Western Cape Blood Service
Do something remarkable

PATIENT INFORMATION AND CONSENT FOR THERAPEUTIC PHLEBOTOMY AT WCBS

PATIENT DETAILS																																
First name																								**Title**								
Surname																																
Email address																																

ID/Passport number:	**Date of birth:**
Cell phone number:	**Age** (new donors must be under 75 years of age)**:**
Address:	
Name of medical aid:	**Medical aid number:**
Name of main member of the medical aid:	

Race (please circle)	White	Asian	Coloured	Black	Other

MEDICAL INFORMATION

Please circle relevant answers	**Gender at birth:** Male | Female	**Weight:** above 50kg | below 50kg

Please list the names of your chronic medications. Alternatively, attach a copy of your medication prescription.

In the last **3 months**, have you been hospitalised ? If yes, please provide the date and reason for admission.	
In the last **3 months**, have you had a procedure using a scope e.g colonoscopy? If yes, please provide the type and date of the procedure.	
Have you ever had any type of cancer? If yes, please indicate the type cancer and when treatment was completed.	
Have you ever had a stroke (CVA), transient ischaemic attack (TIA) or blood clot? If yes, please indicate what occured, when and the treatment received.	
Have you ever had a seizure or been diagnosed with epilepsy? If yes, please indicate the date of the last seizure and when medication was last used.	
Have you ever had an irregular pulse, stent, angina, bypass surgery, pacemaker or heart attack? If yes, please indicate what occurred and the date of the event.	
Have you ever had hepatitis or jaundice? If yes, please indicate when this occurred and the diagnosis.	
Do you have any autoimmune disease eg. rheumatoid arthritis? If yes, please indicate what type and what medication you use for the condition.	
Did you grow up in an area/country where malaria is prevalent? If yes, where, and when did you last visit **any** malaria prevalent area?	
Have you ever had brain surgery or received a tissue or organ transplant? If yes, what type and when?	

CONSENT

I have been referred by my clinician for therapeutic phlebotomy at WCBS. I acknowledge and understand the following:

- My clinician is responsible for my medical management and for prescribing my phlebotomy intervals. It is my responsibility to liaise with my clinician in this regard and to attend WCBS donor centres as prescribed.
- When requiring phlebotomies more frequently than every 56 days (routine donation interval), it is my responsibility to liaise with my clinician to ensure that a prescription is submitted to WCBS prior to me attending the donor centre (phlebotomy@wcbs.org.za). WCBS will facilitate 8 phlebotomies per prescription. Thereafter, I will revert to the routine blood donation interval.
- The Head of the Medical Division at WCBS may require additional tests/medical reports before accepting me as a donor. Donors with a cardiac history may be required to submit ongoing medical reports for review.
- I will be charged for the first therapeutic phlebotomy and for any further phlebotomies where my blood is not suitable for transfusion to patients.
- Following my first phlebotomy, I understand that when my blood is not used for transfusion to patients it may not undergo routine testing for HIV, hepatitis B, hepatitis C, syphilis and ferritin level.
- It is my responsibility to settle all accounts and to liaise with my medical aid as required.
- WCBS has put measures in place to protect and safeguard my personal information and will only share this with my clinician, if necessary.
- Upon visiting the donation centres, I will be required to sign documents related to the Protection of Personal Information (POPI), and I further comprehend that this document is aligned with the content of the POPI document.

Signature:	**Date:**

WCBS Specialised Donations: Email: phlebotomy@wcbs.org.za | Tel: (021) 507 6320/6393

For office use	Donor code											