

CONFIDENTIAL DONOR QUESTIONNAIRE

Section 1 | Personal Details

First-time donors: Complete all sections in full.
Repeat donors: Only complete this section if your personal information has changed.

DATE STAMP

SERIAL NUMBER

Please circle the relevant answers where applicable e.g.

YES NO

SURNAME:						FIRST NAME:											
TITLE:	Prof	Dr	Mr	Mrs	Ms	SEX AT BIRTH: (This is required for your haemoglobin reference range)											
						Male						Female					
DATE OF BIRTH:		D	D	M	M	Y	Y	Y	Y	AGE:							
HOME / POSTAL ADDRESS:						RSA ID NUMBER:											
						FOREIGN PASSPORT NUMBER:											
						TELEPHONE NUMBER (HOME):											
						TELEPHONE NUMBER (WORK):											
						CELL PHONE NUMBER:											
POSTAL CODE:																	
EMAIL ADDRESS:																	
LANGUAGE:		English		Afrikaans		RACE GROUP:		Asian		Black		Coloured		White		Other:	
<p>WCBS randomly selects blood donations collected from all race groups, which are tested for additional blood group systems such as Kell, MNS and Duffy. This enables us to find compatible units for multi-transfused patients or patients with rare blood groups. Knowing the race of each blood donor helps us to ensure that we have enough extended tested units to meet clinical demand. For more details please see WCBS's website.</p>																	
PREFERRED PLACE OF DONATION:																	
I consent to receive notifications and reminders from WCBS.												Yes			No		
If yes, please select by which method (<i>you may select more than one</i>):												SMS		Phone call		Email	
<p>I understand that all calls received from WCBS will be recorded for quality purposes. I understand that although I indicated my preferred method(s) of communication above, WCBS will contact me via telephone after my first donation. I understand that I can withdraw my consent at any time by contacting WCBS. I understand that I will receive the WCBS blood donor newsletter if I select email.</p>																	
I hereby declare that I would like to enrol as a blood donor.						DONOR SIGNATURE:						DATE:					

 Your 1 donation could save up to 3 lives. Thank you for donating blood today!

For office use only:

STATS CODE:		PANEL CODE:		RECEPTIONIST SIGNATURE:													
DEFERRALS:																	
GIFT RECEIVED:									DONOR SIGNATURE:								
Attach the malaria tag to blood pack until (date):																	
DONOR CODE:																	

Section 2 | Health Questionnaire

DATE STAMP

SERIAL NUMBER

Please circle the relevant answers e.g.

YES	NO
-----	----

--

--

Q1. Will you be involved in any of the following activities?

Driving a public or heavy-duty vehicle, working on scaffolding or using power tools in the next 24 hours?	YES	NO
Sky diving, deep-sea diving, flying an aeroplane or mountaineering in the next 3 days?	YES	NO
Participating in a major sporting event (e.g. full marathon or cycling race over 100 km) in the next 7 days?	YES	NO
Having a surgical procedure in the next 6 weeks?	YES	NO

Q2. In the past 3 days:

Have you taken any painkillers, anti-inflammatories or aspirin (including Ecotrin)?	YES	NO
---	-----	----

Q3. In the past 7 days:

Have you had a cold, flu, sore throat, fever, infection, open wound or allergies?	YES	NO
Have you been to the dentist?	YES	NO
Have you had acupuncture, Botox or dry-needling?	YES	NO

Q4. In the past 30 days:

Have you had diarrhoea or vomiting that lasted more than 24 hours?	YES	NO
Have you had an immunisation or vaccination?	YES	NO

Q5. In the past 3 months:

Have you taken any medication (including traditional medication) by mouth or injection?	YES	NO
Have you been admitted to hospital or had a surgical procedure performed in a doctor's room?	YES	NO

Q6. In the past year:

Have you taken part in a drug trial, vaccine trial, or clinical research?	YES	NO
---	-----	----

Q7. In the past 2 years:

Have you used any medication for the treatment of acne, epilepsy, hair-thinning, prostate problems, rheumatoid arthritis or anticoagulation (blood-thinning)?	YES	NO
---	-----	----

Q8. Have you ever had:

Heart (e.g. stents), lung or circulatory problems (e.g. clots) or a bleeding disorder?	YES	NO
Convulsions (fits), epilepsy or strokes?	YES	NO
Cancer, skin cancer (melanoma, basal cell carcinoma, squamous cell carcinoma) or leukaemia?	YES	NO
Diabetes, asthma, tuberculosis (TB) or kidney disease?	YES	NO
A human tissue, bone or organ transplant?	YES	NO
Any other serious illnesses, severe allergic reactions, tropical diseases or used medication not mentioned above?	YES	NO

Q9. Has your doctor advised you to donate blood to treat a medical condition such as high iron, 'thick blood', polycythaemia or haemochromatosis?

	YES	NO
--	-----	----

Q10. Hepatitis:

Have you had yellow jaundice, hepatitis, liver disease or tested positive for hepatitis after 1 year of age?	YES	NO
In the past 3 months, have you been in sexual contact or lived with anyone who has hepatitis (jaundice)?	YES	NO

Q11. Travel history:

Have you or your sexual partner travelled outside South Africa in the last 3 months?	YES	NO
--	-----	----

Q12. Malaria:

Have you had malaria in the past 3 years?	YES	NO
Have you been in a malaria area in the past 3 months?	YES	NO
Did you grow up in a malaria area or country (including Zimbabwe, Botswana or Swaziland)? If 'yes', have you been in any malaria area in the past 3 years?	YES	NO
	YES	NO

Q13. For women only:

Are you pregnant or undergoing fertility treatment?	YES	NO
In the past 3 months have you had a baby, miscarriage or abortion?	YES	NO
Are you breastfeeding?	YES	NO

STAFF SECTION

Section 3 | Lifestyle Questionnaire

DATE STAMP

SERIAL NUMBER

Please circle the relevant answers e.g.

YES NO

DATE STAMP

SERIAL NUMBER

The following questions are of a sensitive nature. The term 'sexual' includes oral, vaginal and anal sex.

Q1. Have you ever:

Tested positive for HIV?	YES	NO
Tested positive for syphilis?	YES	NO

Q2. In the past 2 years have you:

Used antiretroviral (ARV) medication to treat or prevent contracting HIV (i.e. PrEP or PEP) either in a tablet or injection form, or taken part in a clinical trial for these medications?	YES	NO
--	-----	----

Q3. In the past 3 months have you:

Had a tattoo, any piercings, wet cupping or had permanent make-up applied?	YES	NO
Had Raatib, ritual scarring, ritual circumcision, been stabbed or taken part in blood sharing?	YES	NO
Used recreational/party/street drugs by injection?	YES	NO
Injected yourself or been injected with bodybuilding drugs?	YES	NO

Q4. In the past 3 months have you or your sexual partner:

Had a blood transfusion, received any type of blood product, human tissue, bone or organ transplant?	YES	NO
Had a needlestick or skin penetrating injury, eye splash or skin contact with another person's blood?	YES	NO
Had any sexually transmitted disease (STD) including genital herpes, gonorrhoea (drop) or human papilloma virus?	YES	NO

Q5. In the past 3 months (with or without a condom):

Have you had sexual contact with a new person?	YES	NO
Have you had sexual contact with more than one person?	YES	NO
Has your sexual partner had sexual contact with more than one person?	YES	NO
Have you had sexual contact with a person who has tested HIV positive?	YES	NO
Have you had sexual contact with a person who takes money, drugs, gifts or other favours for sex?	YES	NO
Have you received money, drugs, gifts or other favours for sex, or are you a sex worker?	YES	NO
Have you been sexually assaulted?	YES	NO

STAFF SECTION

Please read and sign the Declaration and Consent before donating blood.

Declaration

- I confirm that I am 16 years of age or older.
- I confirm that I weigh 50kg or more.
- I confirm that I have read 'Important Information for Blood Donors' and WCBS' Privacy Statement, and understand and accept the donation process and the related risks as explained to me.
- To the best of my knowledge, all the information I have supplied is the truth. I understand that if I have not answered the questions truthfully, it may endanger patients and lead to legal proceedings against me.
- I undertake to inform WCBS immediately if I think that my blood may not be safe for use.

Consent

- I consent to the testing of my blood for blood group, syphilis, Hepatitis B, Hepatitis C and HIV as well as additional testing that may be necessary to ensure the safety of myself or patients.
- I consent to being contacted using any contact details I have supplied in order to be informed of test results that are important to my health or affect my ability to donate blood.
- I consent to my test results, personal information, and special personal information being kept in a strictly confidential manner for periods in accordance with WCBS' policies, Privacy Statement and legislative requirements.
- I consent to samples of my blood and/or donation data being used anonymously for scientific research aimed at improving the safety of the blood supply and donor health, and that on occasion WCBS may permit researchers to request additional samples from me with my specific consent.
- I consent to my blood products or samples being used for the preparation of diagnostic reagents utilised by blood banks and related medical facilities, and for the production of plasma-derived medicinal products manufactured by the National Bioproducts Institute.
- I consent to receiving medical care (including infusion of fluids and medication) in the event of or to prevent an untoward donor reaction.

NAME AND SURNAME:

DONOR SIGNATURE:

RSA ID NUMBER /

FOREIGN PASSPORT NUMBER:

CELL PHONE NUMBER:

FOR OFFICE USE:

Interview done

YES NO

Staff Signature (Interviewer):

FOR OFFICE USE ONLY

(to be completed by clinic staff members)

DATE STAMP

--

SERIAL NUMBER

--

PRE-DONATION OBSERVATIONS

Hb:	g/dL	Sign:	BP:	Pulse:	Regular	Irregular	Sign:
-----	------	-------	-----	--------	---------	-----------	-------

DONATION PROCEDURE

Donor set-up by: (sign)	HemoFlow Machine No.:
Samples taken by: (sign)	Phlebotomist No. 1: (sign)
Needle removed by: (sign)	Phlebotomist No. 2: (re-needling) (sign)

IRON REPLACEMENT

Iron replacement tablets taken by the donor	Yes	No	Batch No.:	Expiry date:
---	-----	----	------------	--------------

Dispensed by Professional Nurse:
(name & signature)

DONOR ADVERSE EVENTS (please circle answer)

Faint:	Immediate (before leaving the donor clinic)	Delayed (after leaving the donor clinic)	Mild	Moderate	Severe*
--------	--	---	------	----------	---------

* If marked 'Severe', complete all the following information:

Sweating:	Yes	No	Loss of consciousness:	Yes	No	Vomiting:	Yes	No	BP:	Pulse:
Medication administered:	Yes	No	IV Therapy:	Yes	No	Type:	Lot No.:	Expiry date:		

Haematoma:	Mild	Moderate	Severe	Accident:	Immediate (before leaving the donor clinic)	Delayed (after leaving the donor clinic)
Delayed bleed: (returns after having left the clinic)				Citrate reaction:		

DETAILS / COMMENTS

--

QUESTIONNAIRE CHECK AT END OF THE CLINIC

Checked by: _____ Signature: _____