BLOOD DONOR SCREENING FORM

ROTARY BLOOD CENTRE, JODHPUR

(Managed by Rotary Blood Bank Sanchalan Samiti)

K. N. Wanchoo Rotary Bhawan, Gaurav Path, Jodhpur - 342003 (Raj.)

Tel. : 0291-2431558, Mob. : 8824789921.

Blood Unit Number ______________________

Licence No : Raj-2618

Please answer the following questions correctly. This will protect you and the patient (who will receive the blood). Put a mark(✓/ X) at the appropriate place :

Blood Group:

Blood Bank Use Only
Blood Bag Type :
- SB/DB/TB/QB

Capacity - 350 ml ☐ 450 ml ☐

Segment Number

....

Signature of phlebotomist:

Time ....

Time taken: <10 minutes ☐ >10 minutes ☐

QNS ☐ NO BLOOD ☐

Name .... Age .... Gender :- ☐ Male ☐ Female

Date of Birth .... Name of husband/father : ....

Profession : ....

Address ....

E-mail id. : ....

Mobile Number : ....

Classification of Blood Donor: ☐ **Voluntary/**☐ **Replacement**

If replacement blood donor, then name of the Patient ....

Hospital . ... Patient Registration No. ....Req. ID.....................

Have you donated blood before : Yes ☐ No ☐

If yes then how many times? .... When was the last time ....

Have you ever undergone donor apheresis before : Yes ☐ No ☐

If yes then how many times?. ....When was the last time ....

Have you ever had any kind of discomfort during or after donating blood? Yes ☐ No ☐

- Are you feeling healthy today? Yes ☐ No ☐
- Did you eat anything within last 4 hours? Yes ☐ No ☐
- Did you sleep well last night ? Yes ☐ No ☐
- Do you for any reason feel that you may be infected with hepatities, malaria, HIV or AIDS or venereal disease? Yes ☐ No ☐
- Do you take IV narcotic drugs? Yes ☐ No ☐
- Have you experienced any of the following in the last six months ?

☐ Unexplained persistent weight loss ☐ Persistent Low-Grade Fever ☐ Dental treatment
☐ Persistent cough/soreness/sinusitis. ☐ Swollen Glands/nodes ☐ **None of these**

- Have any of the following happened or had any of the following done to you in the last 12 Months?

☐ Tattoo ☐ Acupuncture ☐ Ear/Nose/Navel Holes ☐ Animal bite/rabies vaccine.

- Are you suffering from any of the following diseases?

☐ Heart Disease	☐ Lung Disease	☐ Kidney disease	☐ Cancer
☐ Epilepsy / Seizures	☐ Diabetes (insulin:yes/no)	☐ Abnormal bleeding tendencies	☐ Jaundice
☐ Tuberculosis (TB)	☐ Hepatitis B/C	☐ Alllergy	☐ Mental Illness
☐ Sexually Transmitted Infection	☐ Malaria (past 3 Months)	☐ Leprosy	☐ Asthma
☐ Typhoid (1 year)	☐ Fainting Frequently	☐ Thyroid disease	☐ Polycythemia
☐ Thalassemia	☐ Swelling in Legs	☐ Urinary tract infection	☐ Skin Disease
☐ Auto Immuno Disorder	☐ Bone Disease	☐ Chicken pox (past 2 weeks)	☐ Mumps
☐ Measles (past 2 weeks)	☐ Chikungunya (in the last 6 months)	☐ Dengue (past six months)	☐ Diarrhea (2 weeks)
			☐ None of these

- Does anyone in your family have any of the following ?
  - ☐ Hepatitis B/C ☐ Bleeding Disease ☐ Thalassemia
  - ☐ Tattoo / Body Piercing ☐ HIV/Sexuatly Transmitted Disease ☐ None of these
- Have you ever had sex with multiple women or men ? Yes ☐ No ☐
- Have you consumed / been administered or consume any of the following?
  - ☐ Antibiotics (14 days) ☐ Aspirin (3 Days) ☐ Painkillers ☐ Alcohol (24 hours) ☐ Antihypertensive
  - ☐ Steroids ☐ Vaccine/s ☐ Acne/Pimple Treatment (1 Months) ☐ Anti Thyroid Medicine
  - ☐ Antipyretic (3 Days) ☐ Anticoagulant ☐ Antifungal (14 Days) ☐ **None of These**
- Have you had any surgery or blood transfusion in the last 12 months ?
  - ☐ Major Surgery ☐ Minor Surgery ☐ Blood Transfusion ☐ None of These
- For female blood done -

Are you pregnant:	Yes ☐	No ☐
Have you had a miscarriage in the last 6 months?	Yes ☐	No ☐
Do you have a child under 1 year of age ?	Yes ☐	No ☐
Date of last menstruation	Yes ☐	No ☐
Do you experience abnormal bleeding ?	Yes ☐	No ☐
Are you breast feeding your children ?	Yes ☐	No ☐

- Would you like to be informed about any abnormal tests you may have?
  Yes ☐ No ☐
- Have you read and understood all the above information and answered all the questins truthfully?Any false statement or withholding information may affect you or harm the recipient. Yes ☐ No ☐

I understand that :-

- Blood donation is a completely voluntary act and I have not been offered any inducement of remuneration.
  Donating blood/components is a medical procedure and by voluntarily donating, I accept the risks associated with the procedure.
- My blood will be tested for the diseases hepatitis B, hepatitis C, malaria parasits. HIV and syphilis, which is in addition to any other screening tests that may be needed to ensure blood safety. I prohibit discussing any information I provide or my donation with any person or government agency
- I give permission to the blood bank to process and use my blood for the teatment of the patient.
- I also understand that further blood fractiontion may allow my blood to be used in research or medical products.

Date : .... Time : .... Signature of the Blood Donor ....

FOR BLOOD BANK USE ONLY (MEDICAL OFFICER)

1. Weight ....Kg.
2. Pulse (per minute) ....
3. Blood Pressure .... mm of Hg.
4. Temperature ....^{0}F/^{0}C
5. Hemoglobin .... gm/dl

Blood Donor Accepted ☐

Rejected ☐

Deferred ☐

Reason for deferral/ rejection

....

Signature of Medical Officer

(Blank space for description of blood donor reaction,if any)