KARNATAKA RED CROSS BLOOD BANK

A unit of Indian Red Cross Society
Karnataka State Branch
No. 26, Red Cross Bhavan, 1st Floor, Race Course Road, Bengaluru-560 001
Tel.: 080-1052 (Toll Free) / 22340844, 22268435, Fax. : 22284878
Licence No. KTK/28C/187/2006

Unit No.
Blood Group

BLOOD DONOR QUESTIONNAIRE & CONSENT FORM

CONFIDENTIAL

(✓) Tick wherever applicable

Please answer the following questions truthfully. This will help you and the patient who receives your blood. Please take care of your valuables during donation. The blood bank is not responsible for any loss.

Name : Male/Female

Date of Birth : Age : Husband/Father's Name :

Occupation : Organisation :

Address for communication :

Telephone : Mobile No. :

Would you like us to call on your mobile ☐ Yes ☐ No

Fax No. Email :

Have you donated previously ☐ Yes ☐ No In this Blood Bank ☐ Yes ☐ No

Did you have any discomfort after donation ? ☐ Yes ☐ No

Your Blood group : Time of last meal :

(✓) Tick appropriate answer :

1. Do you feel well today ? ☐ Yes ☐ No
2. Did you have something to eat in the last 4 hours? ☐ Yes ☐ No
3. Did you sleep well last night ? ☐ Yes ☐ No
4. Have you any reason to believe that you may be infected by either Hepatitis, HIV/AIDS and veneral disease ? ☐ Yes ☐ No
5. In the last 6 months have you had any history of the following ☐ Yes ☐ No
   - ☐ Unexplained weight loss
   - ☐ Repeated Diarrhoea
   - ☐ Swollen Glands
   - ☐ Continuous Low - grade fever / Night sweats
   - ☐ Persistent Cough
   - ☐ Tattooing
   - ☐ Ear Piercing
   - ☐ Dental Extraction
   - ☐ IV Drug Abuse
   - ☐ Blood Transfusion
6. In the past 15 days have you been vaccinated for ☐ Yes ☐ No
   - ☐ Cholera
   - ☐ Typhoid
   - ☐ Diphtheria
   - ☐ Tetanus
   - ☐ Plague
   - ☐ Gamma Globulin

7. Do you suffer from or have suffered from any of the following diseases : ☐ Yes ☐ No

☐ Heart Disease	☐ Lung Disease	☐ Polycythemia - vera
☐ Cancer / Malignant disease	☐ Tuberculosis	☐ Kidney Disease (Chronic Nephritis)
☐ Diabetes - Controlled on Insulin	☐ Asthma	☐ Epilepsy
☐ Abnormal bleeding tendency	☐ Mental Disorder	☐ Liver Disease (Hepatitis B/C)
☐ Allergic Disease	☐ Endocrine Disorders	☐ Fainting Spells
☐ Sexually Trans. Disease	☐ Schizophrenia	☐ Leprosy

8. Are you taking or have taken any of these in the past 72 hours ? : ☐ Yes ☐ No

☐ Antibiotics ☐ Steroids ☐ Aspirin ☐ Alcohol

9. Is there a history of any of these in the last 12 months ? ☐ Yes ☐ No

☐ Major Surgery ☐ Minor Surgery ☐ Typhoid ☐ Jaundice ☐ Chickangunya Fever

☐ Dogbite (Rabies) Vaccine / Immunoglobulin ☐ Hepatitis in close family / contact

10. Is there history of malaria and duly treated in the past 6 months (Endemic Area) ☐ Yes ☐ No

Past 3 Years (No Endemic Area) ☐ Yes ☐ No

11. For Women Donors -

a) Are you Pregnant ? ☐ Yes ☐ No

b) Have you had an abortion in the last 6 months ? ☐ Yes ☐ No

c) Do you have a child less than one year old ? ☐ Yes ☐ No

d) Have you had menstrual period? (one week before / after) ☐ Yes ☐ No

12. Would you like to be informed about any abnormal test result at the address furnished by you ?

☐ Yes

13. Have you read and understood all the information presented and answered all the questions truthfully, as any in correct statement or concealment may affect your health or may harm the recipient.

☐ Yes

CONSENT

a) Blood donation is a totally voluntary act and no inducement or remuneration has been offered.

b) Donation of blood / Components is a medical procedure and that by donating voluntarily, I accept the risks associated with the procedure.

c) My blood will be tested for Hepatitis B and C, Malaria parasite, HIV / AIDS and Veneral diseases in addition to any other screening tests required to ensure blood safety.

I prohibit information provided by me or about my donation to be disclosed to any individual or government agency without my prior permission.

I wish to donate blood voluntarily.

Date :..... Time :.....

.....
Donor's Signature

PHYSICAL EXAMINATION

Date of Donation	Weight in Kgs.	Temp	Pulse / Minute	BP / mm of Hg	Hb gms/dl	Blood bag Tube No.	Volume 350/450ml	Type of Bag S/D/T/Q

☐ Deferral ☐ Rejection ☐ Reason :

Site of Phlebotomy : Right / Left

Fit for donation ☐ Yes ☐ No

Signature of Technician / Staff Nurse..... Signature of Medical Officer :.....

BLOOD SAFETY BEGINS WITH A HEALTHY DONOR