



Donor Health Check. Medical - in confidence
Check and complete this side at session



DO NOT USE AFTER

Name

Address

Postcode

E-mail

Ethnicity

Date of Birth

Tel. No. Home

Tel. No. Mobile

Registration No.

Linked Venues

Total Donations
& Badge Award

Blood
Group

DONOR DECLARATION

1. I have read and understood the Donor Information Leaflet, the information overleaf, and the current Health Check Questionnaire which I have completed. I have been given the opportunity to ask questions and they have been answered to my satisfaction.
2. I affirm that, to the best of my knowledge, all the information I have given is correct, and I am not at risk of any of the infections listed in the Donor Information Leaflet.
3. I agree that my blood will be tested for HIV and other conditions listed in the Donor Information Leaflet. I understand that if my blood gives a positive result for any of these tests, I will be informed, and given further advice.
4. I agree to my blood being blood-typed, and a small sample of it being stored.
5. I understand the nature of the donation process and the possible risks involved as explained in the Donor Information Leaflet.
6. I understand SNBTS will hold information about me, my health, my attendances and my donations and will use it for the purposes explained in the Donor Information Leaflet.
7. I agree to donate, and thereby give my blood to SNBTS, to be used for the benefit of patients. This may be by direct transfusion to a patient, or indirectly as explained in the Donor Information Leaflet.

Date:

Read and sign at session

Venue:

Signature

NATF 155 20

Aged 17-19	H	W
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AED Code		
Requires F/U	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Notes		
	Initials	Date
eProgesa update	Initials	Date

					Donation No.					
Last Att & Status	Reg/H.S.	Accept / Defer Code	Recall Date							
Hb Pass/Fail	2nd Hb P/F	Issue	Scale/Machine	Label 1	Label 2	Conclude	Volume			
Hb analyser	Hb analyser VS	Fluids Y / N	AMT Y / N	V.P.	V.P.start	V.P.stop	Sealer	Seal/Check		
Antiplatelet Medication	WNV Test	MAT required	T. cruzi Test	Hep B Core Test	HTLV Test	Linked By	Discard	Donation Hold		
Profile	WB/Serum	Platelet/Leuco	CMV	RC/OAS	18060	FFP	Cryo	Apheresis		

Venue:

Serology:

Date:

Registration Number:

Collection Comments:

Donation No.

NATF 155 20

PLEASE READ THIS IMPORTANT INFORMATION BEFORE COMPLETING THE HEALTH CHECK

Blood Safety starts with you. By answering our questions accurately, you'll be helping to ensure that we'll not harm you by taking your blood, nor harm anyone else by giving your blood to them.

Each time you give blood, please read each question very carefully. Your health or our questions could have changed since your last visit. If you weigh less than 50kg, please let staff know.

HELP US KEEP BLOOD TRANSFUSION SAFE

Never give blood just to get a test. If you do, you risk infecting other people.

If at any time after you have given blood you have doubts about whether your donation should be used, please let us know.

If you want to leave the session without giving blood, that's OK. You don't have to explain why.

The Scottish National Blood Transfusion Service (SNBTS) is a Division of NHS National Services Scotland.

DONATION SAFETY CHECK – IN CONFIDENCE. TO BE COMPLETED BY DONOR

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All Donors	Yes	No	Staff
1. Are you fit and well?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you seen a doctor, dentist or any other healthcare professional in the last 7 days or are you waiting to see one?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medicine or other treatment prescribed by a health care professional? (except HRT for the menopause, the pill or other birth control)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you taken any other medicine or tablets in the last 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any unhealed wounds or broken skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has anyone in your family had CJD (Creutzfeldt-Jakob Disease)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had symptoms of any infections in the past 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been in contact with anyone with an infectious disease in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had any vaccinations in the last 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you work for the emergency services or drive a bus, train or HGV? Will you be working at depth or height in the next 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. What is your job?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you pregnant, or have you been in the last 6 months (if not applicable, please tick No)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only New Donors Or Donors Who Have Not Given For 2 Years (Do not complete this section if you have given in the last 2 years)	Yes	No	Staff
13. Have you ever had a serious illness or medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever seen a doctor about your heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had an operation, or any medical investigations or tests (including endoscopy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had jaundice or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever received a blood transfusion (including Covid-19 plasma) if Yes - where and when?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever been treated by a skin specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you prone to fainting or dizzy spells?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Were you treated with growth hormone before 1986?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Did you have brain or spinal surgery before August 1992?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Were you or your mother born in South America, Central America or Mexico?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had sex with someone who has HTLV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever received fertility treatment for you to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

Donors Who Have Given In The Last 2 Years	Yes	No	Staff
26. Since you last gave blood have you had sex with someone who has HTLV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Since you last gave blood have you had a: <ul style="list-style-type: none"> • Serious illness or infection • Operation • Medical test or investigation • Blood Transfusion (including Covid-19 plasma) 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All Donors - Your Travel History	Yes	No	Staff
28. Were you born outside the UK? If Yes - where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you ever been outside the UK for a continuous period of 6 months or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you ever had malaria or an unexplained fever during or after travel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever visited South America, Central America or Mexico for 4 weeks or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you been outside the UK (including business) in the last 12 months? If Yes - where and when?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All Donors - Blood Safety	Yes	No	Staff
33. Have you ever been diagnosed with, or treated for: <ul style="list-style-type: none"> • HIV • Hepatitis B • HTLV • Syphilis • Hepatitis C 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you ever injected, or been injected with illegal or non-prescribed drugs? This includes bodybuilding drugs, injectable tanning agents and injected chemsex drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you ever had sex with someone who had previously had a viral haemorrhagic fever (e.g. Ebola Fever, Lassa Fever)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. In the last 4 months, have you had: <ul style="list-style-type: none"> • Acupuncture, a tattoo or a piercing • Cosmetic treatments that involve piercing your skin 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. In the last 4 months, have you had an injury which could have put you at risk of hepatitis or HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. In the last 3 months, have you received payment for sex, e.g. money or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. In the last 3 months, have you or anyone you have had sex with been diagnosed or treated for a sexually transmitted infection? (except chlamydia, genital herpes or genital warts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Pre- or Post-Exposure Prophylaxis (PrEP/PEP) to prevent HIV infection: <ul style="list-style-type: none"> • In the last 3 months have you taken oral PrEP or PEP, or • In the last 2 years have you received injections for PrEP? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. In the last 3 months have you had chemsex i.e. use of drugs solely to enhance sexual experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. In the last 3 months, have you had sex with: <ul style="list-style-type: none"> • Anyone who has hepatitis B, hepatitis C, or HIV • Anyone who has ever received payment for sex, e.g. money or drugs • Anyone who has ever injected drugs 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. In the last 3 months, have you had more than one sexual partner, or had a new sexual partner? If yes, did you have anal sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>