

MOD EMERGENCY DONOR PANEL – HEALTH SCREENING QUESTIONNAIRE

If you are uncertain of any question, then please speak to a Health Care Professional in Confidence

A. YOUR LIFESTYLE	Yes	No
A1 Have you tested positive for HIV, or do you think you may be HIV positive?		
A2 Have you ever had Hepatitis or think you may have Hepatitis now?		
A3 Have you ever been injected with illegal or non-prescribed drugs, including body building drugs or tanning agents?		
A4 In the last 3 months have you been given money or drugs for sex?		
A5 In the last 3 months Have you had sex with:	Yes	No
^a anyone who is positive for HIV, Hepatitis, HTLV or Syphilis?		
^b anyone who has ever been given money or drugs for sex?		
^c anyone who has ever injected drugs?		
^d anyone who may ever have had sex in parts of the world where AIDS/HIV is endemic?		
^e a new partner or more than one partner?		
^f if 'yes' to question A5e did you have anal sex?		
B. YOUR INFECTION RISKS	Yes	No
B1 In the last 7 days have you had a Hepatitis B vaccination?		
B2 In the last 4 months , have you had any body piercing or tattoo?		
B3 In the last 4 months , have you had any complementary therapy which has an invasive procedure, e.g. acupuncture?		
B4 In the last 4 months , have you been exposed to someone's blood / body fluid by needle prick, bite or broken skin?		
B5 Have you ever had jaundice?		
B6 Have you ever had or been treated for syphilis?		
B7 In the last 12 months have you shared a home with someone with Hepatitis?		
B8 Have you ever received a blood transfusion or blood product?		
B9 Has anyone in your family had Creutzfeldt-Jakob Disease (CJD)?		
B10 Have you been treated with human growth hormone?		
B11 Have you ever had brain surgery or an operation on your spine?		
B12 In the last 3 months have you had Pre-Exposure Prophylaxis (PrEP) or Post-Exposure Prophylaxis (PEP) for HIV?		
C. YOUR MEDICAL HISTORY	Yes	No
C1 Have you ever been told that you should not give blood?		
C2 Have you ever suffered heart problems or serious illness?		
C3 Have you ever had a surgical operation?		
C4 Are you awaiting any results from medical investigations?		
C5 Are you taking any medication prescribed by a doctor?		
C6 Have you or close relative been diagnosed with Sick cell disease / trait?		
C7 WOMEN only. Have you ever received fertility treatment?		
D. YOUR TRAVEL HISTORY	Yes	No
D1 Whatever your nationality, have you been outside of the UK in the last 12 months?		
D2 Have you ever had malaria or had an unexplained fever which you could have picked up from outside the UK?		
D3 Have you ever visited Central or South America or Mexico for a continuous period of four weeks or more?		
D4 Were you or your mother born in Central, South America or Mexico?		

DONOR DETAILS – Complete in Full		DOCUMENT CLERK ONLY		
		YES responses require detailed comments below. Include dates for any incident, including travel and medical history.		
Service Number				
First Name				
Surname				
Date of Birth				
Contact Number <small>To clarify responses only</small>				
Signature				
Blood Group	IF KNOWN			
ISBT Label	Haemoglobin g/L			Name:
	Sex M / F			

COMPLETE BOTH SIDES OF THE QUESTIONNAIRE

OFFICIAL – SENSITIVE - PERSONAL (When Completed)

Annex D to SOP 0901 V4.1

ISBT Label

DONOR DETAILS		
Surname		
Forename(s)		
Service No.		
Date of Birth	DD / MM / YYYY	Sex: M / F

DONOR CONSENT

1. I have today read and understood the Donor Information Leaflet. I have answered honestly and to the best of my knowledge. I understand the nature of the donation process and the possible risks involved and have been given the opportunity to ask questions.
2. I agree that my blood can be tested for HIV, Hepatitis B C & E, HTLV, Syphilis and, if appropriate, any discretionary tests. I understand that if my blood gives a positive result for any of these tests I will be informed via my senior medical officer and asked to attend for further confirmatory tests and advice.
3. I agree to the Armed Forces and NHS Blood and Transplant holding my personal details on their donor databases and processing this information as required for blood donation tracking.

Signature _____ Date _____

DEFENCE PATHOLOGY PERSONNEL ONLY			
Blood Group Only		Name	
Blood Group + Donor Screening		Signature	Date

NHSBT STAFF ONLY			
R = Risk / Exposure M = Illness / Symptoms L = Long Stay	Malaria Incident Type Incident Date / /	T cruzi Incident Type Incident Date / /	West Nile Virus Incident Date / /
Name		Comments	
Signature			
Date			