DEPARTMENT OF HEALTH
JAMMU AND KASHMIR

# BLOOD DONOR QUESTIONNAIRE AND CONSENT FORM

Blood Unit No :

License No :

Date

Type of Donation: R/V

**CONFIDENTIAL**

**( ) Tick whether applicable.**

01. Please answer the following questions correctly. This will help to protect you and the patient who receives your blood.

02. Name : Male ☐ Female ☐

03. Date of Birth: Age : Father's Name:

04. Occupation : Organization:

05. Address for communication :

06. Telephone : Mobile No:

07. Would you like us to call you on your mobile : ☐ Yes ☐ No.
Would you like your name to included in donor's website ☐ Yes ☐ No.

08. Fax No: Email :

09. Have you donated previously ☐ ☐ No.
If yes, how many occasions when last :

10. Did you have any discomfort during/after donation? ☐ Yes ☐ No.

11. Your Blood Group Time of last meal :

12. Tick the appropriate answer : ( )

13. Do you feel well today ? ☐ Yes ☐ No.

14. Did you sleep well last night ? ☐ Yes ☐ No.

15. Have you any reason to believe that you may be infected :
By Hepatitis, Malaria, HIV and/or venereal disease (virinjay) ? ☐ Yes ☐ No.

16. In the last 6 months have you had any history of the following :-
- ☐ Unexplained weight loss
- ☐ Repeated Diarrhoea
- ☐ Swollen Glands
- ☐ Continuous low – grade fever

17. In the last six months have you had any :-
- ☐ Tattooing.
- ☐ Ear piercing.
- ☐ Dental Extraction.

18. Do you suffer from or have suffered from any of the following diseases?
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Cancer/Malignant Disease
- ☐ Epilepsy (Charay rog)
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ abnormal Bleeding tendency.
- ☐ Hepatitis B/C
- ☐ Allergic Disease
- ☐ Jaundice (last one year).
- ☐ Sexually Transmitted Diseases
- ☐ Malaria (six months)
- ☐ Typhoid ( last on year) (Antay joro)
- ☐ Fainting spells.

19. Are you taking or have you taken any of these in the past 72 hours?

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Alcohol
- ☐ Steroids
- ☐ Vaccinations
- ☐ Dog bite Rabies vaccine (1 year).

20. Is there any history of surgery or blood transfusion in the past six months?
- ☐ Major
- ☐ Minor
- ☐ Blood Transfusion

21. For women donors :-

| | | |
|---|---|---|
| Are you pregnant ? | ☐ Yes | ☐ No. |
| Have you had an abortion in the last three months ? | ☐ Yes | ☐ No. |
| Do you have a child less than one year old? | ☐ Yes | ☐ No. |

22. Would you like to be informed about any abnormal test result at the address furnished by you ?
☐ Yes ☐ No.

23. Have you read and understood all the information presented and answered all the questions truthfully? As any incorrect statement or concealment may affect your health or may harm the recipient? ☐ Yes ☐ No.

24. I have understand that :-
Blood donation is a totally voluntary act and no inducement or remuneration has been offered. Donation of Blood/components is a medical procedure and that by donating voluntarily. I accept the risks associated with this procedure.

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

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

Date ☐☐☐☐☐☐☐☐ Time _____ Donor's Signature _____

25. General Physician Examination :

Weight _____ Pulse _____ Hb_____
BP _____ Temperature_____
☐ Accept ☐ Defer ☐ Reason _____

Signature of Medical Officer_____

**BLOOD SAFETY BEGINS WITH A HEALTHY DONOR.**