Western Cape Blood Service
Do something remarkable

www.wcbs.org.za | info@wcbs.org.za
Head Office
Old Mill Road, Pinelands 7405 • P.O. Box 79, Howard Place 7450
t: 021 507 6300 / f: 021 531 0322

CONFIDENTIAL DONOR QUESTIONNAIRE

DONOR LABEL	DATE STAMP	SERIAL NUMBER

Section 1 | Personal Details

First-time donors: Complete all sections in full.
Repeat donors: Only complete this section if your personal information has changed.

Please circle the relevant answers where applicable, eg (YES) NO

SURNAME: | FIRST NAME:

TITLE: Prof | Dr | Mr | Mrs | Ms

Male | Female

DATE OF BIRTH: D D M M Y Y Y Y AGE:

RSA ID NUMBER:

HOME / POSTAL ADDRESS:

FOREIGN PASSPORT NUMBER:

TELEPHONE NUMBER (HOME):

TELEPHONE NUMBER (WORK):

POSTAL CODE:

CELL PHONE NUMBER:

EMAIL ADDRESS:

LANGUAGE: English | Afrikaans

ETHNIC GROUP: Asian | Black | Coloured | White

PREFERRED PLACE OF DONATION:

I consent to receive notifications and reminders from WCBS.	Yes	No
If yes, please select by which method *(you may select more than one)*.	SMS	Phone call / Email

I understand that all calls received from WCBS will be recorded for quality purposes.
I understand that although I indicated my preferred method(s) of communication above, WCBS will contact me via telephone after my first donation.
I understand that I can withdraw my consent at any time by contacting WCBS.
I understand that I will receive the WCBS blood donor newsletter if I select email.

I hereby declare that I would like to enrol as a blood donor.	DONOR SIGNATURE:	DATE:

Your 1 donation could save up to 3 lives. Thank you for donating blood today!

For office use only:

STATS CODE: | PANEL CODE: | RECEPTIONIST SIGNATURE:

DEFERRALS:

GIFT RECEIVED: | DONOR SIGNATURE:

Attach the Malaria sticker to blood pack until (date):

DONOR CODE:

Section 2 | Health Questionnaire

DATE STAMP

SERIAL NUMBER

Please circle the relevant answers, eg (YES) NO

Q1.	**Will you be involved in any of the following activities?**		
	Driving a public or heavy-duty vehicle, working on scaffolding or using power tools in the next 24 hours?	YES	NO
	Sky diving, deep-sea diving, flying an aeroplane or mountaineering in the next 3 days?	YES	NO
	Participating in a major sporting event (eg full marathon or cycling race over 100 km) in the next 7 days?	YES	NO
	Having a surgical procedure in the next 6 weeks?	YES	NO
Q2.	**In the past 3 days:**		
	Have you taken any painkillers, anti-inflammatories or aspirin (including Ecotrin)?	YES	NO
Q3.	**In the past 7 days:**		
	Have you had a cold, flu, sore throat, fever, infection, open wound or allergies?	YES	NO
	Have you been to the dentist?	YES	NO
	Have you had acupuncture, Botox or dry-needling?	YES	NO
Q4.	**In the past 30 days:**		
	Have you had diarrhoea or vomiting that lasted more than 24 hours?	YES	NO
	Have you had an immunisation or vaccination?	YES	NO
Q5.	**In the past 3 months:**		
	Have you taken any medication (including traditional medication) by mouth or injection?	YES	NO
	Have you been admitted to hospital or had a surgical procedure performed in a doctor's room?	YES	NO
Q6.	**In the past year:**		
	Have you taken part in a drug trial, vaccine trial, or clinical research?	YES	NO
Q7.	**In the past 2 years:**		
	Have you used any medication for the treatment of acne, epilepsy, hair-thinning, prostate problems, rheumatoid arthritis or anticoagulation (blood-thinning)?	YES	NO
Q8.	**Have you ever had:**		
	Heart (eg stents), lung or circulatory problems (eg clots) or a bleeding disorder?	YES	NO
	Convulsions (fits), epilepsy or strokes?	YES	NO
	Cancer, skin cancer (melanoma, basal cell carcinoma, squamous cell carcinoma) or leukaemia?	YES	NO
	Diabetes, asthma, tuberculosis (TB) or kidney disease?	YES	NO
	Any other serious illnesses, severe allergic reactions, tropical diseases or used medication not mentioned above?	YES	NO
Q9.	**Has your doctor advised you to donate blood to treat a medical condition such as high iron, 'thick blood', polycythaemia or haemochromatosis?**	YES	NO
Q10.	**Hepatitis:**		
	Have you had yellow jaundice, hepatitis, liver disease or tested positive for hepatitis after 13 years of age?	YES	NO
	In the past 3 months, have you been in sexual contact or lived with anyone who has hepatitis (jaundice)?	YES	NO
Q11.	**Travel history:**		
	Have you or your sexual partner travelled outside South Africa **in the last 3 months?**	YES	NO
Q12.	**Malaria:**		
	Have you had malaria **in the past 3 years?**	YES	NO
	Have you been in a malaria area **in the past 3 months?**	YES	NO
	Did you grow up in a malaria area or country (including Zimbabwe, Botswana or Swaziland)?	YES	NO
	If 'yes', have you been in **any** malaria area **in the past 3 years?**	YES	NO
Q13.	**Variant Creutzfeldt-Jakob Disease (vCJD) – also known as mad cow disease:**		
	Have you ever had brain surgery, received a dura mater (brain covering) graft or taken pituitary growth hormone?	YES	NO
	Have you or your sexual partner ever received a tissue, human cornea or organ transplant?	YES	NO
	Were you residing in the United Kingdom for a total period of 12 months or longer between Jan. 1980 and Dec. 1996?	YES	NO
Q14.	**For women only:**		
	Are you pregnant or undergoing fertility treatment?	YES	NO
	In the past 3 months have you had a baby, miscarriage or abortion?	YES	NO
	Are you breastfeeding?	YES	NO

STAFF SECTION

DONOR LABEL

DATE STAMP

SERIAL NUMBER

Section 3 | Lifestyle Questionnaire

Please circle the relevant answers, eg (YES) NO

The following questions are of a sensitive nature. The term 'sexual' includes oral, vaginal and anal sex.

Q1.	**Have you ever:**		
	Tested positive for HIV?	YES	NO
	Injected yourself or been injected with bodybuilding drugs?	YES	NO
	Injected yourself or been injected with recreational/party/street drugs?	YES	NO
Q2.	**In the past 3 months have you:**		
	Had a tattoo, any piercings, cupping or had permanent make-up applied?	YES	NO
	Had Raatib, ritual scarring, ritual circumcision, been stabbed or taken part in blood sharing?	YES	NO
	Had a needlestick or skin penetrating injury, eye splash or skin contact with **another** person's blood?	YES	NO
Q3.	**In the past 3 months have you or your sexual partner:**		
	Had a blood transfusion or received any type of blood product?	YES	NO
	Used recreational/party/street drugs by nose or mouth, including cannabis (weed, marijuana)?	YES	NO
	Used antiretroviral (ARV) medication as treatment for HIV or to prevent contracting HIV (i.e. PrEP or PEP)?	YES	NO
	Had any sexually transmitted disease (STD) including genital herpes, syphilis, gonorrhoea (drop) or human papilloma virus?	YES	NO
Q4.	**In the past 3 months (with or without a condom):**		
	Have you had sexual contact with a new person?	YES	NO
	Have you had sexual contact with more than one person?	YES	NO
	Has your sexual partner had sexual contact with more than one person?	YES	NO
	Have you had sexual contact with a person who has tested HIV positive?	YES	NO
	Have you had sexual contact with a person who takes money, drugs or other favours for sex?	YES	NO
	Have you received money, drugs or other favours for sex, or are you a sex worker?	YES	NO
	Have you been sexually assaulted?	YES	NO

STAFF SECTION

Please read and sign the Declaration and Consent before donating blood.

Declaration

1. I confirm that I am 16 years of age or older.
2. I confirm that I have read 'Important Information for Blood Donors' and WCBS' Privacy Statement, and understand and accept the donation process and the related risks as explained to me.
3. To the best of my knowledge, all the information I have supplied is the truth. I understand that if I have not answered the questions truthfully, it may endanger patients and lead to legal proceedings against me.
4. I undertake to inform WCBS immediately if I think that my blood may not be safe for use.

Consent

1. I consent to the testing of my blood for blood group, syphilis, Hepatitis B, Hepatitis C and HIV as well as additional testing that may be necessary to ensure the safety of myself or patients.
2. I consent to being contacted using any contact details I have supplied in order to be informed of test results that are important to my health or affect my ability to donate blood.
3. I consent to my test results, personal information, and special personal information being kept in a strictly confidential manner for periods in accordance with WCBS' policies, Privacy Statement and legislative requirements.
4. I consent to samples of my blood and/or donation data being used anonymously for scientific research aimed at improving the safety of the blood supply and donor health, and that on occasion WCBS may permit researchers to request additional samples from me with my specific consent.
5. I consent to my blood products or samples being used for the preparation of diagnostic reagents utilised by blood banks and related medical facilities, and for the production of plasma-derived medicinal products manufactured by the National Bioproducts Institute.
6. I consent to receiving medical care (including infusion of fluids and medication) in the event of or to prevent an untoward donor reaction.

NAME AND SURNAME: _____ SIGNATURE: _____

RSA ID NUMBER / FOREIGN PASSPORT NUMBER: _____ CELL PHONE NUMBER: _____

FOR OFFICE USE: Interview done YES NO Signature (Interviewer): _____

FOR OFFICE USE ONLY
(to be completed by clinic staff members)

DONOR LABEL	DATE STAMP	SERIAL NUMBER

PRE-DONATION OBSERVATIONS

Hb: g/dL	Sign:	BP:	Pulse:	Regular	Irregular	Sign:

DONATION PROCEDURE

Donor set-up by:
(sign)

HemoFlow Machine No.:

Samples taken by:
(sign)

Phlebotomist No. 1:
(sign)

Needle removed by:
(sign)

Phlebotomist No. 2: (re-needling)
(sign)

IRON REPLACEMENT

Iron replacement tablets taken by the donor	Yes	No	Batch No.:	Expiry date:

Dispensed by Professional Nurse:
(name & signature)

DONOR ADVERSE EVENTS (please circle answer)

Faint:	**Immediate** (before leaving the donor clinic)	**Delayed** (after leaving the donor clinic)		**Mild**	**Moderate**	**Severe***

*** If marked 'Severe', complete all the following information:**

Sweating:	Yes	No	**Loss of consciousness:**	Yes	No	**Vomiting:**	Yes	No	**BP:**	**Pulse:**

Medication administered:	Yes	No		**IV Therapy:**	Yes	No
Type: Lot No.: Expiry date:				Type: Lot No.: Expiry date:		

Haematoma:	Mild	Moderate	Severe		**Accident:**	**Immediate** (before leaving the donor clinic)	**Delayed** (after leaving the donor clinic)
Delayed bleed: (returns after having left the clinic)					**Citrate reaction:**		

DETAILS / COMMENTS

QUESTIONNAIRE CHECK AT END OF THE CLINIC

Checked by:

Signature: