



# LIONS BLOOD BANK

(Regional Blood Transfusion Centre (North - West), SBTC, DELHI, Licence No. 1899

## 100% VOLUNTARY BLOOD DONATION

AK-100, Shalimar Bagh, Delhi-110 088

Tel. No.: 47122000 Mob. : 9717897500, 20

Email : lionsbloodbank@hotmail.com

LBB/DOC/NUR/001.1



## DONOR REGISTRATION, SELECTION AND CONSENT FORM

Bag Type :	Segment No	DONOR ID
DB 350 <input type="checkbox"/> DB 450 <input type="checkbox"/> QB <input type="checkbox"/>		
TB 350 <input type="checkbox"/> TB 450 <input type="checkbox"/> ITB <input type="checkbox"/>	Lot No	

Camp Name

Camp Date DD MM YY Time Hrs. Min.

**PLEASE FILL THIS FORM IN CAPITAL LETTERS**

Donor Name

Age  Yrs Sex  M  F other  Occupation

Date of Birth DD MM YY Nationality  Indian  Others Marital Status  Unmarried  Married

Father's/Husband's Name

Address

Pin Code  Mobile

Tel : (off.)  Resi. with code

E-mail

Your Blood Group  A  B  AB  O  POS.  NEG.  Don't Know

Predonation counselling By \_\_\_\_\_

Answer the following honestly and correctly. These are for your safety and the safety of patients who will receive your blood. This information will remain confidential. If you have any illness not covered here please tell the interviewer.

Have you donated blood earlier :  Yes  No If YES, date of last donation.....

Have you donated blood earlier with Lions Blood Bank:  Yes  No If YES, date of last donation or Donor ID

Have you been previously deferred, if yes, reason .....

Have you ever experienced any problem after donation  Yes  No

Do you want to be a Regular Voluntary Donor  Yes  No

If yes, how often would you like to donate :  3 Monthly  6 Monthly  Life Saving Ambassador Programme

LSAP : ON CALL DONOR FOR LIFE SAVING EMERGENCIES

**Tick ✓ the Appropriate Answer**

1. Are you in Good Health Today? Do you feel well ?  Yes  No

2. Do you have something to eat in last 4 hours  Yes  No

3. Did you sleep well last night  Yes  No

**4. Do you suffer or have suffered from any of the following diseases?**

Lung Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer / Malignant Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Abnormal bleeding tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B/C	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Jaundice (Last 1 year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergic Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Malaria (6 months)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Sexually Trans. Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If you have any other illness  
not covered here please mention

**5. Have you any reason to believe that you may be infected by either Hepatitis, HIV/AIDS, and, or Sexually Transmitted Disease?**

Yes  No

**6. In last 6 months have you had history of the following?**

Unexplained weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tattooing (1 year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chiken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Persistent Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear Piercing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Repeated Diarrhoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dental Extraction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dengue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Major Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Continuous low grade fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Minor Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Dog Bite / Rabies Vaccine (1 year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

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

Antibiotics  Yes  No Aspirin  Yes  No Alcohol  Yes  No

Steroid  Yes  No Vaccinations  Yes  No Any Other .....

**8. For Female Donors ?**

Are you pregnant  Yes  No When did you have last menstrual Period.....

Have you had an abortion in last six months  Yes  No Do you have a child less than one year old  Yes  No

**9. Would you like to be informed about any abnormal test result at the address furnished by you.**  Yes  No

**DECLARATION AND CONSENT :** I declare that I have read and understood the information regarding blood donation and answered all the questions honestly and correctly. I agree that the blood donated by me voluntarily be used for the benefit of the patients, in any manner as decided by the Blood Bank, for making blood components and plasma, fractionation and derivation of essential plasma derived medicines, transfer to blood to other banks. Donation of blood is a medical procedure and by donating blood voluntarily. I accept the risk associated with this. I give my consent to test my donated blood for Hepatitis B, Hepatitis C, HIV, Malaria Parasite and venereal disease in addition to any other screening tests required to ensure blood safety.

I would like to informed about any abnormal test result by Letter, Phone, SMS, e-mail : Yes No

Transfer of Blood to other blood banks

The staff on duty provided me the opportunity to ask questions and refuse consent.

Signature of Donor

**FOR BLOOD BANK USE ONLY**

Physical Examination : Hb (gm%)   •

Weight (Kg.)

Height   •

Hb Done by ..... Equipment no.

Temperature (Deg.)

Pulse / min

Blood Pressure (mmHg)   /

Condition of Phlebotomy site.....

Accept  Defer

Cause of Deferal.....

Temporary Defer

Permanent Defer

Donor Reaction (if any) :

Haematoma <input type="checkbox"/>	Mild Vasovagal <input type="checkbox"/>
Nausea <input type="checkbox"/>	Hyperventilation <input type="checkbox"/>
Vomiting <input type="checkbox"/>	Syncope <input type="checkbox"/>
Dizziness <input type="checkbox"/>	Convulsion <input type="checkbox"/>

Phlebotomy :

Start Time	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
End Time	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Duration	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
BCM No.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Blood Collection

Completed	<input type="checkbox"/> <input type="checkbox"/>
Uneventful	<input type="checkbox"/> <input type="checkbox"/>
Less Collection	<input type="checkbox"/> <input type="checkbox"/>

Action Taken.....

1017K20

Name & Signature of Technician / Phlebotomist

Signature of Medical Officer