

Donor Registration Form

S.No.	Following are the conditions when you should not donate blood. Please tick as applicable and consult the medical officer if you have any doubts	Y/N								
1.	<p>Do you have or have ever had any of the following?</p> <table border="0"> <tr> <td>Abnormal bleeding disorders</td> <td>Cancer</td> </tr> <tr> <td>Heart, kidney, Lung or Liver disorders</td> <td>Uncontrolled High BP</td> </tr> <tr> <td>Endocrine disorders Santosh baaisas</td> <td>Insulin deocendent diabetes</td> </tr> <tr> <td>Allergic Disorders Nice</td> <td>Polycythemia vera</td> </tr> </table>	Abnormal bleeding disorders	Cancer	Heart, kidney, Lung or Liver disorders	Uncontrolled High BP	Endocrine disorders Santosh baaisas	Insulin deocendent diabetes	Allergic Disorders Nice	Polycythemia vera	
Abnormal bleeding disorders	Cancer									
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Endocrine disorders Santosh baaisas	Insulin deocendent diabetes									
Allergic Disorders Nice	Polycythemia vera									
2.	<p>Have you ever had any of the following risk factors for HIV/AIDS, STDs or Hepatitis?</p> <p>Had sex in exchange for money or drugs</p> <p>Intravenous Drug Abuse</p> <p>Tested positive for HIV, STDs or Hepatitis B or C</p> <p>Had sex with a person who has any of the above risk factors</p>									
3.	<p>Have you had any of the following in the last one year?</p> <table border="0"> <tr> <td>Surgery</td> <td>Typhoid</td> </tr> <tr> <td>Blood tranfusion</td> <td>Rabies vaccination</td> </tr> <tr> <td>Jaundice or close contact with anyone who had jaundice</td> <td></td> </tr> </table>	Surgery	Typhoid	Blood tranfusion	Rabies vaccination	Jaundice or close contact with anyone who had jaundice				
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4.	<p>Have you had any of the following in the last 6 months?</p> <p>Having sex (vaginal, anal or oral), with more than one person, without using condom</p> <p>Tattooing or body piercing</p> <p>Unexplained weight loss or continuous low-grade fever</p> <p>Malaria</p> <p>Dental Extraction, Root canal treatment</p>									
5.	Have you ever had aspirin or drugs containing aspirin in the last 3 days?									
6.	Are you taking antibiotics or any other medicine now?									
7.	Are you well today?									
8.	Have you eaten in the last 4 hours?									
9.	<p>For female donors:</p> <p>Are you pregnant?</p> <p>Have you had an abortion in the last 6 months?</p> <p>Are you breast feeding?</p> <p>Do you have your periods now?</p>									
	Signature of Counselor/MO: _____	Date: _____								

Digital Partner



Donate Blood, Save a Life

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