National Blood Service Ghana

Donor Clinical Record

Date _____ Venue _____

1. PERSONAL INFORMATION

1.1 **Title** ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Prof ☐ Other 1.2 **First Name** _____

1.3 **Last Name** _____ 1.4 **Calling Name** _____

1.5 **Date of Birth** [DD/MM/YY] _____ 1.6 **Sex** ☐ Male ☐ Female

1.7 **Area of Residence** _____ 1.8 **Address (Workplace)** _____

1.9 **Occupation**_____ 1.10 **ID Number** _____

1.11 **ID Type** ☐ National ID ☐ Passport ☐ Driver's License ☐ Voter ID ☐ NHIS Card ☐ Student ID ☐ Employment ID

1.12 **Phone Number** ☐☐☐☐☐☐☐☐☐☐ 1.13 **E-mail** _____

1.14 **Preferred Contact Method** ☐ Phone ☐ SMS ☐ E-mail ☐ Do not contact for blood donation

2. DONATION HISTORY

2.1 **Have you donated blood before?** ☐ Yes ☐ No 2.2 **If Yes, last donation date?** [DD/MM/YY] _____

2.3 **How many times as Voluntary** _____ **Replacement** _____ 2.4 **Donor Card #** _____

3. REPLACEMENT/FAMILY DONORS ONLY

3.1 **Name of Patient** _____ 3.2 **Hospital** _____

3.3 **Ward**_____ 3.4 **Relationship to Patient** _____

Name of Clerking Officer _____ Signature of Clerking Officer_____

Please turn over to proceed to Section 4 →

OFFICE USE ONLY

5. DONOR SELECTION

5.1 **Appearance** ☐ Passed ☐ Failed 5.2 **Medical History** ☐ Passed ☐ Failed 5.3 **Weight** _____kg

5.4 **Blood Pressure** _____mmHg 5.5 **Pulse** _____bpm 5.6 **Hb by $CuSO_4$** ☐ Passed ☐ Failed

5.7 **Hb checked** _____ g/dL 5.8 **HBsAg checked**? ☐ Yes ☐ No HBsAg Result_____

5.9 **Outcome of Screening:**

Qualifies to Donate	**Permanently Deferred**	**Temporarily Deferred**	
☐ Yes ☐ No	☐ High Risk Behaviour ☐ Medical Condition ☐ Test Outcome	☐ Low Hb ☐ Low Weight ☐ Medical Condition ☐ Iron Stores Risk ☐ TTI Risk ☐ Other _____	*Duration of Temporary Deferral* ☐ 1 week ☐ 1 month ☐ 6 months ☐ ≥1 year ☐ Other _____
Comments:		**Name of Nurse**	**Signature**

6. BLOOD DONATION

6.1 **Donation Number**: _____ 6.2 **Pack Type** ☐ Single ☐ Double ☐ Triple ☐ Quad

6.3 **Bleed Time**: Start _____ End _____ ☐ Dry Pack ☐ Apheresis ☐ Test Only ☐ Did not bleed

6.4 **Outcome of Phlebotomy** ☐ Successful
☐ Unsuccessful please specify: ☐ Venous Access ☐ Underbled _____mL ☐ Donor Reaction

6.5 **Donor Adverse Event:** ☐ Vasovagal Reaction (mild) ☐ Vasovagal Reaction (complicated or with injury)
☐ Haematoma/Abnormal Bleed ☐ Painful Arm ☐ Multiple Pricks ☐ Other

Name of Nurse _____ **Signature**_____

4. HEALTH QUESTIONNAIRE

Blood donation should be safe for both the donor and the eventual recipient of the blood donated. The following questions will help us determine whether it is safe for YOU to donate blood today, and whether the blood is likely to be safe enough to give to a sick person. We cannot rely entirely on laboratory tests, as they may not always be able to detect infectious agents and other problems, so please answer the questions TRUTHFULLY. Thank you!

Please check "✓" in the boxes and qualify responses by underlining the specific item that applies.

1.	Are you feeling well today, i.e. no fever, cough, headache or cold?	Yes ☐	No ☐
2.	Have you ever been deferred as a blood donor or told not to donate blood? If Yes, for what reason? _____	Yes ☐	No ☐
3.	Are you taking medication? If Yes, for what condition? _____ and what medication? _____	Yes ☐	No ☐
4.	Have you had, or do you have epilepsy, stomach ulcer, heart disease or cancer?	Yes ☐	No ☐
5.	Have you had tuberculosis?	Yes ☐	No ☐
6.	Have you been vaccinated in the last 4 weeks? If Yes, what vaccine?_____	Yes ☐	No ☐
7.	Have you had jaundice, liver disease or a positive blood test for hepatitis?	Yes ☐	No ☐
8.	Do you have sickle cell disease (not sickle trait, 'AS'), or joint pains that usually occur during cold seasons?	Yes ☐	No ☐
9.	Have you ever injected yourself with drugs or medication?	Yes ☐	No ☐
10.	Have you in the last 6 months had a needle-stick injury or an injection in a place that is not a hospital or clinic; or skin scarring/tattoo; or cutting by a traditional healer (including circumcision)?	Yes ☐	No ☐
11.	Have you ever had a headache?	Yes ☐	No ☐
12.	Have you had dental treatment in the last 1 week, or taking antibiotics now?	Yes ☐	No ☐
13.	Have you in the past 6 months had any surgery with general anaesthesia?	Yes ☐	No ☐
14.	Have you in the last 6 months received blood or blood component transfusion?	Yes ☐	No ☐
15.	Have you in the last 6 months lost more than 5kg in weight unintentionally?	Yes ☐	No ☐
16.	Have you in the last 6 months had unprotected sex with more than one partner or have paid/been paid to have sex?	Yes ☐	No ☐
17.	Have you ever had gonorrhoea, genital or urinary pain or discharge?	Yes ☐	No ☐
18.	[For Men Only] Have you in the last 6 months had sex with a man?	Yes ☐	No ☐
19.	Have you or your partner ever tested positive for HIV (AIDS)?	Yes ☐	No ☐
20.	After blood donation, are you going to take part in any vigorous activity, such as climbing, driving a heavy vehicle, operating heavy machinery, or working at hazardous areas or heights?	Yes ☐	No ☐
21.	Are you coming to donate blood because you have been told you have too much blood?	Yes ☐	No ☐
22.	Have you been pregnant in the last 12 months or currently breastfeeding?	Yes ☐	No ☐

Additional question(s) _____

_____

Refer to the *"Medical History Selection Guide for Donor Attendants"* in the Donor Selection & Care Manual to guide your evaluation of the donor.

Donor Declaration

I have read and understood the NBSG donor information leaflet "**Giving Blood - Frequently Asked Questions**". I confirm that the information I have provided regarding my current state of health, previous illnesses, medication history and sexual health are TRUE and CORRECT to the best of my knowledge. I understand my blood will be tested for HIV, Hepatitis B, Hepatitis C and Syphilis and I have no reason to believe I am a carrier of any. I understand that if my donation gives a positive result for any of these tests, I will be contacted and informed, and may be asked for further confirmatory tests and advice. I understand that any incorrect answer to the questions above may harm my health or that of a person who will receive the blood I donate. I understand my donation may be used by the Blood Service or mandated organizations for the purpose of research, teaching, quality assurance or the making of essential diagnostic reagents, and samples of my blood may be stored for possible future testing and research. I agree to the National Blood Service holding information about me, my health, my intended and actual blood donations, and using it for the purposes of information, patient and donor safety, audit, research as stated in the donor information leaflet. Therefore, I consent to all the above, and I give my blood to the National Blood Service to be used for the benefits of patients. I promise to notify the Blood Service/Blood Bank of any change to the information I have provided as soon as I am aware of it.

Donor's Signature _____ Counsellor's Name & Signature _____ Date _____