



Garth Englund Blood Center
Blood Donor Record

Legal last name	Legal first name (no nicknames)	Middle initial	Last 4 digits of SSN	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing address		City		State	Zip
<input type="checkbox"/> Home phone <input type="checkbox"/> Mobile phone	Email			Preferred method of contact	Estimated weight
Date	Donor ID	Blood Type	ID Check	Eligibility Check	Comments for Phlebotomist

Please mark the appropriate box for each question response. You may NOT draw a line down through the answers.

Are you:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Feeling healthy and well today? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Currently taking an antibiotic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Currently taking any other medication for an infection? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 4. Taken any medications on the Medication Deferral List in the time frames indicated?
(Review the Medication Deferral List.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Read the educational materials today? | <input type="checkbox"/> | <input type="checkbox"/> |

In the **past 48 hours**, have you:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 6. Taken aspirin or anything that has aspirin in it? | <input type="checkbox"/> | <input type="checkbox"/> |

In the **past 8 weeks**, have you:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 7. Donated blood, platelets, or plasma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Had any vaccinations or other shots? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Had contact with someone who was vaccinated for smallpox in the past 8 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |

In the **past 3 months**, have you:

- | | Yes | No |
|--|-------------------------------------|--------------------------|
| 10. Had a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Had a transplant such as organ, tissue, or bone marrow? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Had a graft such as bone or skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Come into contact with someone else's blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Had an accidental needle-stick? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Had sexual contact with anyone who has ever had HIV/AIDS or has ever had a positive test for the HIV/AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Had sexual contact with a prostitute or anyone else who has ever taken money or drugs or other payment for sex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything <u>not</u> prescribed by their doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Male donors. Had sexual contact with another male? | <input type="checkbox"/> N/A Female | <input type="checkbox"/> |
| 19. Female donors. Had sexual contact with a male who had sexual contact with another male in the past 3 months? | <input type="checkbox"/> N/A Male | <input type="checkbox"/> |
| 20. Had a tattoo? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Had ear or body piercing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Had or been treated for syphilis or gonorrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Used needles to take drugs, steroids, or anything <u>not</u> prescribed by your doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Received money, drugs, or other payment for sex? | <input type="checkbox"/> | <input type="checkbox"/> |

In the **past 16 weeks**, have you:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 25. Donated a double unit of red cells using an apheresis machine? | <input type="checkbox"/> | <input type="checkbox"/> |

For office staff only

		Yes	No
In the past 12 months , have you:			
26.	Had sexual contact with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Lived with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
28.	Been in juvenile detention, lockup, jail, or prison for 72 hours or more consecutively?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 3 YEARS , have you:			
29.	Been outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>
From 1980 through 1996 , did you:			
30.	Spend time that adds up to 3 months or more in the United Kingdom countries of England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands?	<input type="checkbox"/>	<input type="checkbox"/>
From 1980 through 2001 , did you:			
31.	Spend time that adds up to 5 years or more in France or Ireland? Time spent in Ireland does not include time spent in Northern Ireland which is part of the United Kingdom.	<input type="checkbox"/>	<input type="checkbox"/>
From 1980 to the present , did you:			
32.	Receive a blood transfusion in France, Ireland, England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands?	<input type="checkbox"/>	<input type="checkbox"/>
Have you EVER :			
33.	Female donors. Been pregnant or are you pregnant now?	<input type="checkbox"/> N/A	<input type="checkbox"/>
34.	Had a positive test for the HIV/AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
35.	Had malaria?	<input type="checkbox"/>	<input type="checkbox"/>
36.	Received a dura mater (or brain covering) graft or xenotransplantation product?	<input type="checkbox"/>	<input type="checkbox"/>
37.	Had any type of cancer, including leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
38.	Had any problems with your heart or lungs?	<input type="checkbox"/>	<input type="checkbox"/>
39.	Had a bleeding condition or a blood disease?	<input type="checkbox"/>	<input type="checkbox"/>
40.	Had a positive test for <i>Babesia</i> ?	<input type="checkbox"/>	<input type="checkbox"/>
Additional questions			
41.	In the past 3 months , have you taken any medication to prevent an HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
42.	Have you EVER taken any medication to treat an HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
43.	Have you ever been diagnosed with hepatitis B or hepatitis C infection, at any age?	<input type="checkbox"/>	<input type="checkbox"/>
44.	Have you ever lived in another country for 5 years or longer?	<input type="checkbox"/>	<input type="checkbox"/>
45.	Female donors. Most recent pregnancy date _____ (includes all pregnancies)	<input type="checkbox"/> N/A	

I have volunteered to be a whole blood donor. I understand that there is a limit to the number and types of components that I can donate each year.

The hazards of the procedure include the following: (1) Complications such as a hematoma (bruise), localized infection at the venipuncture site, nerve or tendon injury, thrombophlebitis, or delayed and/or excessive bleeding from the needle site; (2) Vasovagal symptoms including severe sweating, nausea, vomiting, light headedness, fainting, or seizures. These symptoms may vary from mild to life threatening.

I agree not to donate if I feel that my lifestyle puts me at risk for being exposed to or contracting infectious hepatitis and/or the AIDS virus. I understand that I may call back after my donation if I feel that I need to notify someone that I may be in a high-risk group.

I have received complete information regarding research protocols associated with any investigational testing that may currently be required by the FDA. I agree that my blood may be used in the research protocol presented to me. I understand that waste blood may be used for research projects.

I have had an opportunity to ask questions about this procedure. I understand the blood donation process, and the risks of the procedure. I have had a chance to refuse to donate. I certify that I have answered all questions truthfully regarding my travel history, present and prior illnesses, symptoms and physical conditions. I voluntarily donate my blood to Garth Englund Blood Center (part of UCHealth) to use at its discretion.

Donor signature

Date

Witness signature

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If **EIDORADO Donor IN USE**, following section not required. If **EIDORADO Donor NOT in use**, complete the following:

Pulse	Blood pressure/Equipment ID	Temperature/Equipment ID	Hematocrit/Equipment ID	Tech	Arm check
Scale ID	Bag lot	Start time	Elapsed time	DIN	
Site	Donor acceptable for donation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluated and drawn by			