The Tamil Nadu Dr. M.G.R. Medical University

Department of Transfusion Medicine

Licence No. 191/28C

BLOOD DONOR FORM

Blood Bag No.	Date			Group & Rh

PERSONAL PARTICULARS

Donor's Name:	Age : D.O.B. :	Sex : Male / Female
Occupation:	Marital Status: Married / Unmarried	

Residential Address	Office Address
.....	.....
.....	.....
.....	.....
Mobile/Ph :.....	Mobile/Ph :.....
Email :.....	Email :.....

KIND ATTENTION

Kindly Furnish the following information sought on medical grounds as per Government Notification. If any question is felt embarrassing kindly bear with us.

To ensure your safety as a blood donor and the safety of the patients who will receive your blood, please read the information leaflet provided and answer this questionnaire correctly. If you have any difficulty in filling this form please ask for help from Blood centre staff. All details given by you will be confidential.

GENERAL QUESTIONS:	
• Are you feeling well today?	Yes / No
• Have you had 5 – 6 hours of sleep at night?	Yes / No
• When was your last meal?	
• When was your last donation?	
• How many times have you donated?	
Donation interval- For whole blood donation, once in three months (90 days) for males and four months (120 days) for females.	
• Have you consumed alcohol within 24 hours?	Yes / No
• Are you an aircrew, a heavy machine vehicle driver, a construction worker?	Yes / No
• History of any recent travel to other countries	Yes / No

Physiological Status for Women	
• Have you recently delivered within 12 Months?	Yes / No
• Have had an Abortion within 6 months?	Yes / No
• Are you Breast feeding your child currently?	Yes / No
• Are you menstruating?	Yes / No
Non-specific illness	
• Have you suffered from any Minor non-specific symptoms (General malaise, Pain, Headache)?	Yes / No
Respiratory (Lung) Diseases	
• Are you suffering from Cold, flu, cough, sore throat or acute sinusitis?	Yes / No
• Are you on suffering from chronic sinusitis?	Yes / No
• Have you had an asthmatic attack? Are you on steroids for Asthma?	Yes / No
Surgical Procedures	
• Have you had any Major surgery in the last 12 months ?	Yes / No
• Have you had any Minor surgery in the last 6 months?	Yes / No
• Have you Received Blood Transfusion in the last 12 months?	Yes / No
• Have you undergone Open heart surgery Including Bypass surgery?	Yes / No
• Have you undergone Cancer surgery?	Yes / No
• Have you undergone Tooth extraction Defer in the last 6 months?	Yes / No
• Have you undergone Dental surgery under anesthesia in the last 6 months?	Yes / No
Cardio-vascular diseases (Heart disease) [If yes, permanently defer]	
• Do you have any active symptom (Chest Pain, Shortness of breath, Swelling of feet)?	Yes / No
• Have you suffered from Myocardial infarction?	Yes / No

• Are you on any Cardiac medication (Digitalis, Nitroglycerine)?	Yes / No
• Are you suffering from Hypertensive heart disease?	Yes / No
• Are you suffering from Coronary artery disease?	Yes / No
• Are you suffering from Angina pectoris?	Yes / No
• Are you suffering from Rheumatic heart disease?	Yes / No
Central Nervous System/ Psychiatric Diseases	
• Are you suffering from Migraine?	Yes / No
• Are you suffering from Convulsions and Epilepsy?	Yes / No
• Are you suffering from Schizophrenia?	Yes / No
• Are you suffering from Anxiety and mood disorders?	Yes / No
Endocrine Disorders	
• Are you suffering from Diabetes?	Yes / No
• Are you suffering from any Thyroid disorders?	Yes / No
• Are you suffering from any other endocrine disorders ?	Yes / No
Liver Diseases and Hepatitis infection	
• Are you a diagnosed case of Hepatitis B, C?	Yes / No
• Have you suffered from Hepatitis A or E in the last 12 months?	Yes / No
• Is your Spouse/ partner/ close contact of individual suffering with hepatitis in the last 12 months?	Yes / No
• Have you or Spouse/ partner had any tattoos, acupuncture or body piercing, scarification and any other invasive cosmetic procedure in the last 12 months?	Yes / No
• Has your Spouse/ partner of individual received blood transfusion in the last 12 months?	Yes / No
• Have you suffered from Jaundice (Due to gall stones, Rh disease, mononucleosis or in neonatal period) ?	Yes / No
• Have you suffered from Chronic Liver Disease/ Liver Failure?	Yes / No

STD /HIV Infection	
• Are you a t risk for HIV infection (Transgender, Men who have Sex with Men, Female Sex Workers, Injecting drug users, persons with multiple sex partners)?	Yes / No
• Are you a Known HIV positive person or spouse/ partner of PLHA (person living with HIV AIDS)?	Yes / No
• Do you have any symptoms suggestive of AIDS (Night Sweats, Persistent Fever, Unexplained Weight loss, Swollen Glands, Persistent Diarrhoea)?	Yes / No
• Are you suffering from Syphilis (Genital sore or generalized skin rashes)?	Yes / No
• Are you suffering from Gonorrhoea?	Yes / No
Other infectious /Non infectious diseases	
• Do you have any History of Measles, Mumps, Chickenpox in the last 2 weeks?	Yes / No
• Have you suffered from Malaria in the last 3 months?	Yes / No
• Have you suffered from Typhoid in the last 12 Months?	Yes / No
• Have you suffered from Dengue/ Chikungunya in the last 6 Months?	Yes / No
• Have you suffered from Zika Virus/ West Nile Virus in the last 4 months?	Yes / No
• Have you suffered from Tuberculosis?	Yes / No
• Have you suffered from Leishmaniasis?	Yes / No
• Have you suffered from Leprosy?	Yes / No
Other infections	
• Have you suffered from Conjunctivitis?	Yes / No
• Have you suffered from Osteomyelitis in the last 2 years?	Yes / No
Kidney Disease	
• Have you suffered from Acute infection of kidney in the last 6 months?	Yes / No
• Have you suffered from Acute infection of bladder (cystitis) / UTI in the last 2 weeks?	Yes / No
• Have you suffered from Chronic infection of kidney/ kidney disease/ renal failure?	Yes / No

Digestive System	
• Have you suffered from Diarrhea in the last 2 weeks?	Yes / No
• Have you undergone GI endoscopy in the last 12 months?	Yes / No
• Are you suffering from Acid Peptic disease?	Yes / No
• Are you suffering from Stomach ulcer with symptoms or with recurrent bleeding?	Yes / No
Other diseases/ disorders	
• Are you suffering from Autoimmune disorders like Systemic lupus erythematosis, scleroderma, dermatomyositis, ankylosing spondylitis or severerheumatoid arthritis?	Yes / No
• Are you suffering from Polycythemia Vera?	Yes / No
• Are you suffering from Bleeding disorders and unexplained bleeding tendency?	Yes / No
• Are You suffering from malignancy/ cancer Disorders?	Yes / No
• Are you suffering from Severe allergic disorders?	Yes / No
• Are you suffering from Haemoglobinopathies and red cell enzyme deficiencies with known history of hemolysis?	Yes / No
Vaccination and inoculation	
• Have you taken Typhoid, Cholera, Papillomavirus, Influenza, Meningococcal, Pertussis, Pneumococcal, Polio injectable, Diphtheria, Tetanus, Plague vaccine in the last 14 days?	Yes / No
• Have you taken Polio oral, Measles(rubella), Mumps, Yellow fever, Japanese encephalitis, influenza,Typhoid,Cholera, Hepatitis A vaccine in the last 28 days?	Yes / No
• Have you taken Anti-tetanus serum, anti-venomserum, Anti - diphtheria serum, anti-gas gangrene serum in the last 28 days?	Yes / No
• Have you taken Anti-rabies vaccination following animal bite in the last one year?	Yes / No
• Have you taken Hepatitis B Immunoglobulin in the last one year ?	Yes / No
• Have you taken Swine Flu vaccine in the last 15 days?	Yes / No

Medications taken by prospective blood donor	
• Have you taken/taking Oral contraceptive ?	Yes / No
• Have you taken/taking Analgesics?	Yes / No
• Have you taken/taking Vitamin?	Yes / No
• Have you taken/taking Mild sedative and tranquillizers?	Yes / No
• Have you taken/taking Allopurinol?	Yes / No
• Have you taken/taking Cholesterol lowering medication?	Yes / No
• Have you taken/taking Salicylates (aspirin), NSAIDs ?	Yes / No
• Have you taken/taking Ketoconazole, Antihelminthic in the last 7 days?	Yes / No
• Have you taken Antibiotics in the last 2 Weeks?	Yes / No
• Have you taken Ticlopidine, clopidogrel in the last 2 Weeks ?	Yes / No
• Have you taken Piroxicam, dipyridamole in the last 2 Weeks ?	Yes / No
• Have you taken Etretinate, Acitretin or Isotretinoin in the last one month?	Yes / No
• Have you taken Finasteride in the last 1 month ?	Yes / No
• Have you taken Dutasteride in the last 6 months?	Yes / No
• Have you taken/taking Oral anti-diabetic drugs?	Yes / No
• Have you taken/taking Anti-arrhythmic, Anticonvulsant, Anticoagulant, Antithyroid drugs, Cytotoxic drugs, Cardiac Failure Drugs (Digitalis)?	Yes / No
Other conditions requiring Permanent deferral	
• Are you a Recipient of organ, stem cell and tissue transplants?	Yes / No
• Did you experience any unexplained delayed faint or delayed faint with injury or two consecutive faints following a blood donation?	Yes / No
Resident of other countries	
Are you staying in India continuously for 3 years	Yes / No

Covid -19	
• Past History of Covid -19 infection, If Yes, 28 days completed after infection	Yes / No
• History of fever, Cold, Cough & Difficulty in Breathing	Yes / No
• History of Travel to Containment Zone	Yes / No
History of Covid -19 Vaccination (1st dose/ 2nd dose – 14 days interval)	

Consent:

I understand that blood Donation is a totally voluntary act and no inducement or remuneration has been offered. I declare that all the information I am providing in this document are true to the best of my knowledge. I am aware that blood donation is a medical procedure, I accept the risks associated with this procedure. I am also aware that certain tests (HIV, Hepatitis B, Hepatitis C, Syphilis and Malaria) will be performed to ensure the safety. I declare that I am willing to donate a unit of my blood that may be used for therapeutic, production of components, quality control material and research purposes.

I would like to be informed about any abnormal test results done on my donated blood: Yes/No.

If Yes, I may be informed through my contact address/e-mail/Mobile/Telephone Number.

Donor's Signature **Signature of Medical Officer**

PHYSICAL EXAMINATION

Wt. (in Kg)	HB gm %	PR	BP	RR	TEMP.	CVS	RS	CNS	ABD	Skin disease at phlebotomy site

The above donor is ***Accepted/ Temporary Deferral / Permanent Deferral*** to donate blood

Blood Bag: SINGLE / DOUBLE / TRIPLE/ QUADRUPLE

Volume: 350 ml / 450 ml

Name of the Phlebotomist	
Check Donor's Name	YES / NO
Check Donation No. with Form/ Blood Bag	YES / NO
Volume of the Bag	
Time Taken in minutes	
Bag Segment No.	
Sign. Of the Phlebotomist	

Remarks :

Signature of the Medical Officer