MELVIN JONES MEMORIAL LIONS CHARITABLE TRUST

Sunnambu Kolathur Main Road, Kovilambakkam, Chennai - 600 117

(Sponsored by Lions Club of Keelkattalai)

DONOR REGISTRATION, SELECTION AND CONSENT FORM

Bag Type :		
DB 350 ☐	DB 450 ☐	QB ☐
TB 350 ☐	TB 450 ☐	ITB ☐

Segment No

Lot No

DONOR ID

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.) with code

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 Ambassdor 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

P.T.O.

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

Lung Diseases	☐ Yes	☐ No	Kidney Diseases	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Cancer / Malignant Disease	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	If you have any other illness		
Abnormal bleeding tendency	☐ Yes	☐ No	Hepatitis B/C	☐ Yes	☐ No	not covered here please mention		
Jaundice (Last 1 year)	☐ Yes	☐ No	Allergic Diseases	☐ Yes	☐ No			
Malaria (6 months)	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No	.....		
Sexually Trans. Diseases	☐ Yes	☐ No	Typhoid	☐ Yes	☐ No			

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	☐ Yes	☐ No	Tattooing (1 year)	☐ Yes	☐ No	Chiken Pox	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No	Ear Piercing	☐ Yes	☐ No	Mumps	☐ Yes	☐ No
Repeated Diarrhoea	☐ Yes	☐ No	Dental Extraction	☐ Yes	☐ No	Dengue	☐ Yes	☐ No
Swollen glands	☐ Yes	☐ No	Major Surgery	☐ Yes	☐ No			
Continuous low grade fever	☐ Yes	☐ No	Minor Surgery	☐ Yes	☐ No			
Dog Bite / Rabies Vaccine (1 year)	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ 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	☐	Mild Vasovagal	☐
Nausea	☐	Hyperventilation	☐
Vomitting	☐	Syncope	☐
Dizziness	☐	Convulsion	☐

Phlebotomy :

Start Time	
End Time	
Duration	
BCM No.	

Blood Collection

Completed Uneventful	☐
Less Collection	☐

Action Taken.....

Name & Signature of Technician / Phlebotomist

Signature of Medical Officer