

Manual Updates to Donor File (Mobile Clinics)

Surname: _____
 1st Name & Inits: _____
 Title: _____ Birth date: _____ Gender: _____
dd/mm/yyyy
 Request New ID Card: _____ (Initials)
 PROGESA Updated by: _____

Registration Information

1. Donor's Clinic of last attendance:
 CBS HQ Unknown N/A

2. Additional Prior Surnames: N/A

Additional Information: _____

Supplementary Test: <input type="checkbox"/> Remote Status Check (7210)	Hgb g/L	Hgb g/L	Hct L/L
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Confirmed Phlebotomy Type: <input type="checkbox"/> W Whole Blood <input type="checkbox"/> D Directed <input type="checkbox"/> R WBC/Plt Antibody <input type="checkbox"/> S Specimen <input type="checkbox"/> * Not Drawn <input type="checkbox"/> E Platelets <input type="checkbox"/> P Plasma <input type="checkbox"/> C Concurrent Plasma <input type="checkbox"/> F Directed Platelet <input type="checkbox"/> L Source Plasma	Reg/Tech:	Reg only:	Tech only:
	1st Deferral: Code:	Start Date: dd/mm/yyyy	
	End Date, if Req'd: dd/mm/yyyy	Remove Code:	
	2nd Deferral: Code:	Start Date: dd/mm/yyyy	
	End Date, if Req'd: dd/mm/yyyy	Remove Code:	



Phlebotomy Status: - Phlebotomy OK **H** Deferred -H.I.
 B Bedside Deferral **V** Unsuccessful Venepuncture
 J Donor W.O. **U** Apheresis - Aborted Run

Blood Pressure:	Pulse:	Temp.:	PLACE BAR CODED CUE LABEL HERE
1. _____	1. _____	1. _____	
2. _____	2. _____	2. _____	DONATION NUMBER LABEL
Notifiable Donor: <input type="checkbox"/> No - Reason: <input type="checkbox"/> 06 - Donor Request <input type="checkbox"/> 07 - Medical Enquiry <input type="checkbox"/> 04 - CBS Staff Request		Skin Lesions: <input type="checkbox"/> Yes <input type="checkbox"/> No	

1st VENEPUNCTURE Start Bleed Time: _____ + _____ min. Arm: L _____ R _____ Inits: _____	2nd VENEPUNCTURE Start Bleed Time: _____ + _____ min. Arm: L _____ R _____ Inits: _____
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Chagas Risk:
 Lived in risk area Yes No
 Born in risk area Yes No
 Mother/Maternal Grandmother Yes No

Sterile Glove Used <input type="checkbox"/> Alternate Prep Used <input type="checkbox"/>	Sterile Glove Used <input type="checkbox"/> Alternate Prep Used <input type="checkbox"/>
Pack Type: _____ Spec Labelling Inits: _____	Pack Type: _____ Spec Labelling Inits: _____
Shaker #: _____	Shaker #: _____
Unit Labelling Inits: _____	Unit Labelling Inits: _____

Female Apheresis Donors:
 Do you have a history of any pregnancy, including miscarriage or abortion? Yes No

Technical Questionnaire Information:
 Incomplete Spec Set: RT# _____ PT#: Serology _____ NAT _____
 No B19
 No Specimens
 No unit - specs for all tests
 Specimen Labelling Anomaly
 Contains ASA
 Contaminated
 Clamping Error/Sterility Breach
 Sterility Breach
 Labelling Non-Conform
 A/C Volume Unknown
 Other: _____

Comments:
 Donor Information Sheet: Hgb/Hct BP

Verification Inits:	Data Entry Completed By: _____ Inits	Verification of Data Entry Done By: _____ Inits
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RECORD OF DONATION

 DONATION
NUMBER LABEL

ANSWER YES OR NO TO QUESTIONS 1 THROUGH 13, FILL IN THE SQUARE LIKE THIS YES NO Collection Staff Comments

1. a) Are you feeling well today?	<input type="checkbox"/>	<input type="checkbox"/>	Collection Staff Comments
b) Do you have a cold, flu, sore throat, fever, infection or allergy problem today?	<input type="checkbox"/>	<input type="checkbox"/>	
2. a) In the last 3 days have you taken any medicine or drugs (pills including Aspirin or shots), other than birth control pills and vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	
b) In the last 3 days have you had dental work?	<input type="checkbox"/>	<input type="checkbox"/>	
3. In the last month have you had an AIDS (HIV) test other than for donating blood?	<input type="checkbox"/>	<input type="checkbox"/>	
4. a) In the last 3 months have you had a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	
b) In the last month have you taken Accutane, Clarus (isotretinoin), Tactino (alitretinoin), Proscar, Propecia (finasteride), or Cyclomen (danazol)?	<input type="checkbox"/>	<input type="checkbox"/>	
5. a) In the last 6 months have you been under a doctor's care or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
b) If female, in the last 6 months have you been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
c) In the last 6 months have you taken Avodart, Jalyn (dutasteride) or Methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>	
d) In the last 6 months have you had a tattoo, ear or skin piercing, acupuncture or electrolysis?	<input type="checkbox"/>	<input type="checkbox"/>	
e) In the last 6 months have you had an injury from a needle or come in contact with someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>	
6. a) In the last 12 months have you had a rabies shot or a graft?	<input type="checkbox"/>	<input type="checkbox"/>	
b) In the last 12 months have you had close contact with a person who has had hepatitis or yellow jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	
c) In the last 12 months have you been in jail or prison?	<input type="checkbox"/>	<input type="checkbox"/>	
7. a) In the last 12 months have you travelled outside Canada or the U.S. and stayed less than 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
b) In the last 3 and a half years have you spent more than 6 months in a continuous period outside Canada or the U.S.?	<input type="checkbox"/>	<input type="checkbox"/>	
8. a) Since 1980, did you receive a blood transfusion or blood product in the United Kingdom, France or elsewhere in Europe?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you spent a total of 3 months or more in the United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, or the Channel Islands) from January 1, 1980 through December 31, 1996?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Have you spent a total of 3 months or more in France from January 1, 1980 through December 31, 1996?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Have you spent a total of 6 months or more in Saudi Arabia from January 1, 1980 through December 31, 1996?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Have you spent a total of 5 years or more in Europe since January 1, 1980?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have you ever had malaria?	<input type="checkbox"/>	<input type="checkbox"/>	
10. a) Have you ever taken Tegison or Soriatane for skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you ever taken human pituitary growth hormone or received a dura mater (brain covering) graft?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you ever had:			
a) yellow jaundice (other than at birth) or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	
b) epilepsy, coma, stroke or fainting?	<input type="checkbox"/>	<input type="checkbox"/>	
c) cancer, diabetes or Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>	
d) heart, kidney, lung or blood problems?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Chagas' disease, babesiosis or leishmaniasis?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Are you aware of a diagnosis of Creutzfeldt-Jakob Disease among any of your blood relatives (parent, child, sibling)?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Have you, in your past or present job, taken care of or handled monkeys or their body fluids?	<input type="checkbox"/>	<input type="checkbox"/>	

STOP HERE

 YES NO Collection Staff Comments

14. a) Have you spent a total of 6 months or more in a continuous period in Mexico, Central America or South America?	<input type="checkbox"/>	<input type="checkbox"/>	Collection Staff Comments
b) Were you born in Mexico, Central America or South America?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Was your mother or grandmother born in Mexico, Central America or South America?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Do you have AIDS or have you ever tested positive for HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Have you used cocaine within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Have you taken illegal steroids by needle in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
18. At any time since 1977, have you taken money or drugs for sex?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Male donors: Have you had sex with a man, even one time since 1977?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you ever taken illegal drugs with a needle, even one time?	<input type="checkbox"/>	<input type="checkbox"/>	
21. Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Have you had sex with anyone who has AIDS or has tested positive for HIV or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Female donors: In the last 12 months, have you had sex with a man who had sex, even one time since 1977 with another man?	<input type="checkbox"/>	<input type="checkbox"/>	
24. Have you had sex in the last 12 months with anyone who has ever taken illegal drugs or illegal steroids with a needle?	<input type="checkbox"/>	<input type="checkbox"/>	
25. At any time in the last 12 months, have you paid money or drugs for sex?	<input type="checkbox"/>	<input type="checkbox"/>	
26. At any time in the last 12 months, have you had sex with anyone who has taken money or drugs for sex?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you had sex in the last 6 months with anyone who has taken clotting factor concentrates?	<input type="checkbox"/>	<input type="checkbox"/>	
28. In the last 12 months, have you had or been treated for syphilis or gonorrhoea?	<input type="checkbox"/>	<input type="checkbox"/>	
29. In the last 12 months, have you received blood or blood products by transfusion for any reason, such as an accident or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
30. In the past 6 months, have you had sex with someone whose sexual background you don't know?	<input type="checkbox"/>	<input type="checkbox"/>	
31. a) Were you born in or have you lived in Africa since 1977?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Since 1977, did you receive a blood transfusion or blood product in Africa?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Have you had sexual contact with anyone who was born in or lived in Africa since 1977?	<input type="checkbox"/>	<input type="checkbox"/>	

I have answered all questions truthfully. I understand that to make a false statement is a serious matter and could harm others. I have been given and understand information regarding the procedure, side effects and complications associated with my whole blood or automated donation. I have read and understand the information on how the AIDS (HIV) virus may spread by donated blood and plasma. I agree not to make a donation if there is a chance this might spread the AIDS (HIV) virus. I agree to my donation being tested for HIV, hepatitis and other infections and that my positive test results will be given to me. I agree to donate blood for use as decided by Canadian Blood Services. I agree to call Canadian Blood Services if after donating I decide my blood should not be used.

Donor's Signature: _____
Date: _____

Staff Use Only

Donor Accepted: Yes No

R.N./Designate Signature: _____