BLUT SPENDEN RETTET LEBEN

HEALTH QUESTIONNAIRE

ÖSTERREICHISCHES ROTES KREUZ
TIROL

Surname		Date of birth	D D M M Y Y Y Y
Given name		Sex	female male
Street name		No.	Top
Post code	City or town		
Telephone number			
Email			

BLOOD DONOR ELIGIBILITY (TO BE COMPLETED BY THE BLOOD DONATION FACILITY TEAM)

FIRST-TIME DONOR REPEAT DONOR NA? YES NO

NOTES:

INITIALS:

RR: PULSE: TEMP: HB:

DONOR'S LABEL

V (STANDARD)
M (THROMBO)
X

O (NR with PCR)
U (NR without PCR)
only BG

SIGNATURE DGKS/KP

MUSTER-SAMPLE

Dear donor,

Thank you very much for your willingness to donate blood. Without help from people like you, we would be unable to meet the immense need for stored blood in hospitals. Please read the information for donors and complete this questionnaire shortly before donating blood.

1	Do you feel healthy?	YES NO
2	Do you weigh more than 50 kg?	YES NO
3	Have you ever donated blood, blood platelets, blood plasma or double red cells? If yes, when was your last donation?	YES NO
	If yes, have you tolerated well these previous blood donations?	YES NO
4	For female donors: Are you or have you been pregnant in the last 6 months or are you nursing? If yes, until when were you pregnant?	YES NO
5	Female donors: Have you ever given birth to a child?	YES NO
6	Are you currently under a physician's care, on sick leave or in rehabilitation? If yes, since when and why?	YES NO
7	Do you take any medications regularly? If yes, which ones and when did you last take them?	YES NO
	During the last 4 weeks, have you taken any medications (e.g., painkillers, antibiotics, hormones) or received any injections? If yes, which ones and when was the last time this happened?	YES NO
8	During the last 12 months, have you taken any acne medication (e.g., Isotretinoin, Ciscutan), or	YES NO
	medication intended to prevent a viral infection (e.g., HIV)?	YES NO
	During the last 3 years, have you taken the medication Acitretin (e.g., Neotigason, Keracutan) to treat a skin condition?	YES NO
9	During the last 4 weeks, have you had a dental procedure or a minor surgical procedure (e.g., removal of a mole) performed?	YES NO
10	Have you been immunized (including oral immunization) during the last 4 weeks? If so, against what?	YES NO
11	During the last 12 months, have you received a passive immunisation (e.g., to protect you from rabies after an animal bite)?	YES NO
12	Do you consume drugs (including party drugs such as MDMA/Ecstasy)? Do you abuse drugs, alcohol or medications?	YES NO
13	Have you ever injected or snorted drugs?	YES NO
14	Have you ever injected body building supplements?	YES NO
15	Do you currently have an allergy or are you currently undergoing desensitization?	YES NO
16	Do you currently have inflamed broken skin or a skin rash, fever blisters, blisters in the mouth or on other parts of the body?	YES NO
17	Did you have a tick bite during the last 8 weeks?	YES NO
18	During the last 4 weeks, did you have any minor infection (e.g., cough or cold), an infection with fever (fever above 38°C), diarrhoea, or contact with persons who had infectious diseases (e.g., flu, measles, mumps)?	YES NO

19	During the last 4 months, have you been tattooed (including permanent make-up), have you had your ear or other body parts pierced, or have you undergone acupuncture?	☐ YES ☐ NO
	If yes, did this take place in a medical institution?	☐ YES ☐ NO
20	Have you been in contact with another person's blood during the last 4 months?	☐ YES ☐ NO
21	During the last 4 months, did you have a fever of unknown origin, swollen lymph nodes, night sweats or unexplained weight loss?	☐ YES ☐ NO
22	During the last 4 months, have you been hospitalised or were you treated in a medical facility (e.g., severe accident, major surgery, gastroscopy or colonoscopy, endoscopy, treatment with central vein access, permanent catheter)?	☐ YES ☐ NO
23	During the last 6 months, did you have close contact with persons (e.g., life partner or caregiver of family member) who suffer from hepatitis B, hepatitis C, HIV, syphilis or tuberculosis?	☐ YES ☐ NO
24	Do you have or have you had a cardiovascular disease (high blood pressure, heart failure, heart attack, cardiac arrhythmia, tendency to faint, stroke, circulatory problems, thrombosis)?	☐ YES ☐ NO
25	Do you or did you have a chronic gastrointestinal disease, respiratory disease, autoimmune disease, coagulation disorders, diabetes, epilepsy, cancer, kidney disease, rheumatism, osteomyelitis, neurological disorder?	☐ YES ☐ NO
26	Have you ever received stored blood and/or clotting factors? If yes, when and why?	☐ YES ☐ NO
27	Have you been outside of Austria during the last 6 months? If yes, where?	☐ YES ☐ NO
28	Were you born outside of Europe or have you ever spent more than 6 consecutive months outside of Europe?	☐ YES ☐ NO
29	During the last 4 weeks, have you been in an area with West Nile virus infections, such as in a current Europeanarea at risk (e.g., Eastern Austria, Hungary, Northern Italy) or the US, Canada?	☐ YES ☐ NO
30	Have you had any of the following infectious diseases: HIV, liver inflammation (hepatitis), syphilis, Chagas disease, dengue fever, leishmaniasis, leprosy, babesiosis, HTLV-1/2, rickettsial disease, sleeping sickness, malaria or others?	☐ YES ☐ NO
31	During the last 2 years, did you have tuberculosis, Q fever, toxoplasmosis, brucellosis, Lyme disease or, during the last 6 months, toxoplasmosis or mononucleosis (glandular fever)?	☐ YES ☐ NO
32	Have you or a family member ever been diagnosed with Creutzfeld-Jakob disease or another disease caused by prions (vCJD), or was such a disease ever suspected?	☐ YES ☐ NO
33	Between 1980 and 1996, did you spend more than 6 months total in the United Kingdom / Great Britain and Northern Ireland? Have you received stored blood or clotting factors in that country after 1980?	☐ YES ☐ NO
34	Were you treated with growth hormones or another pituitary extract before 1990?	☐ YES ☐ NO
35	Have you had a stereotactic operation (brain surgery via probe)?	☐ YES ☐ NO
36	Have you ever received donor organs or human/animal tissue (e.g., corneal transplantation, cerebral cortex transplantation, heart valves, bones, cartilage, live cells)?	☐ YES ☐ NO
37	In the last 4 months, have you been intimate with a person suffering from a sexually transmitted disease? (e.g., HIV, Hepatitis B, Hepatitis C, HIV, Syphilis)?	☐ YES ☐ NO
38	In the last 3 months, have you been intimate with more than 3 partners, or have you been intimate with a person of whom you know or assume that they have had more than 3 sexual partners over the last 3 months?	☐ YES ☐ NO
39	In the last 4 weeks, have you had unprotected intercourse (including on a single occasion) with a new partner?	☐ YES ☐ NO

I agree to have blood and blood components collected from me. The blood is used to prepare blood products and is tested for various illnesses and health-related blood test results (such as HIV).	☐ YES ☐ NO
Residual material from the blood donation can be used for scientific purposes, e.g., for the development of new testing methods.	☐ YES ☐ NO
I have received, read and understood the information about possible infectious diseases (e.g. AIDS), complications of blood donations and voluntary self-exclusion (see information for donors).	☐ YES ☐ NO
Donor risks in the context of the blood donation have been explained to me. I had the opportunity to ask questions and my questions were answered fully.	☐ YES ☐ NO
I explicitly consent to have the Austrian Red Cross inform me in writing, by telephone, by text message or by e-mail about activities in connection with blood donation drives. I can revoke this consent at any time by e-mailing datenschutz@roteskreuz-tirol.or calling +43 (0)57144 699.	☐ YES ☐ NO

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DECLARATION

- I declare that none of the risk factors listed in the blood donor information are present in my case. I am aware that infectious diseases (such as HIV, hepatitis B, hepatitis C) can be transmitted by my blood. I have answered all questions to the best of my knowledge.
- I acknowledge that the data collected in the context of my donation, blood analyses performed and the health questionnaire are processed by both the blood donation facilities operated by the Austrian Red Cross and the blood bank of the specific hospital while observing privacy law and other legal principles (in particular, blood safety law, blood donor regulation), and that such data is transmitted by these entities for the purposes listed in the privacy notice.
- I acknowledge that I can participate actively in road traffic no earlier than 30 minutes after the blood donation. If I experience symptoms of an illness within the next 14 days, I must immediately inform the blood donation facility.
- I have received the data privacy information about blood donations; that information is displayed and available for free at the blood donor service.

✆ Call 0800-190 190 for any questions on donating blood

ELIGIBLE DONOR ☐ YES ☐ NO	Blood donation facility team Signature and approval	Donor Date and signature