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HONG KONG RED CROSS
BLOOD TRANSFUSION SERVICE

BLOOD DONATION REGISTRATION FORM

PART I: PRE-DONATION INFORMATION

Thank you for coming to give blood today. Your donation could save and change the lives of the recipients. We sincerely request you to read our blood donation information thoroughly. **To protect your safety in giving blood and the safety of the recipients of your donation, it is vital that we review your suitability to donate today.** If you are uncertain about any questions in this form or in need of more blood donation information, please talk to our nurse on duty.

After donation, your blood will be stringently tested for, inter alia, blood groups and infectious diseases, before processed into blood products. Donations that meet all the quality and safety standards will be issued for patient use in Hong Kong. However, some will be selected for quality assurance testing, academic or medical research. In addition, it may be made available to patients outside Hong Kong for humanitarian considerations or if there is a genuine surplus to local needs.

Giving blood is not completely risk-free as adverse reactions may occasionally happen during blood donation. In general, these reactions are usually mild and short-lasting which include bruising, pain, inflammation, infection or skin allergy around the needle puncture site, dizziness or fainting after donation. For apheresis donation, a small proportion of donors might sometimes experience slight tingling sensation or numbness in fingers and around the mouth, muscle cramping etc. due to low calcium level during apheresis donation. In the event of adverse reactions, our nurse will provide on-site care and arrange referral to nearby hospital for treatment if necessary. For more details on blood donation (including apheresis donation), please refer to the ***Blood Donation Info Pack*** available at our donor centres and website before giving blood. You are also recommended to follow the instructions listed on the ***Post-Donation Advice*** given to you upon your donation.

We would use your contact information (name, address, phone number and email) provided in this form to keep you informed of blood donation activities. In addition, if your blood is tested positive for any of the infection, we shall inform you accordingly. Should you have any queries, please feel free to ask our nurse on duty.

SAFE BLOOD SAVE LIVES

NOT ALL BLOOD BORNE INFECTIONS CAN BE DETECTED BY LABORATORY TESTS. PLEASE HELP US ENSURE BLOOD SAFETY AND DO NOT PROCEED TO DONATE IF YOU SUSPECT THAT YOUR BLOOD MAY CARRY A POTENTIAL RISK OF INFECTION OR IF YOU WANT TO HAVE YOUR BLOOD TESTED.

FOR FREE HIV TESTING, PLEASE CONSULT YOUR DOCTOR OR CALL 2780 2211.

If you find this blood donation registration form, please contact our staff at 2710 1333.

PART II: HEALTH SCREENING AND INFECTION RISK ASSESSMENT

You are required to answer the following questions honestly by putting a "✓" in the correct box. If you do not understand any questions in this form or not certain how to respond, please leave the question blank and seek clarification from our nursing staff later. Our nurse will review your responses, answer your questions and discuss with you IN CONFIDENCE to determine if you can donate today. The information you disclose will be kept in strict confidence. Thank you.

General Health Screening	YES	NO	Staff Use	
A1. Are you feeling well enough to give blood today?				A1
A2. Are you currently under a doctor's treatment, taking any medication (including herbal medicine) or awaiting test result?				A2
A3. Have you ever been diagnosed of the following illnesses?				
• cardiovascular diseases (e.g. chest pain, hypertension)				A3a
• respiratory diseases (e.g. asthma)				A3b
• gastrointestinal or liver diseases (e.g. inflammatory bowel disease, hepatitis)				A3c
• blood diseases (e.g. bleeding problem, previously received clotting factor concentrates)				A3d
• cancers				A3e
• endocrine or metabolic diseases (e.g. diabetes, thyroid diseases)				A3f
• neurological diseases (e.g. loss of consciousness, epilepsy)				A3g
• mental disorders				A3h
• kidney or urogenital diseases (e.g. nephritis, kidney or bladder stones)				A3i
• autoimmune or rheumatological diseases (e.g. SLE, rheumatoid arthritis)				A3j
A4. Have you ever been diagnosed of G6PD deficiency?				A4
A5. Have you ever taken the following drugs?				
• aspirin or any drugs containing aspirin				A5a
• non-steroidal anti-inflammatory drugs				A5b
• drugs for hair loss				A5c
• drugs for benign prostatic hypertrophy				A5d
• drugs for acne				A5e
A6. Have you ever had drug allergy? If yes, please specify:_____				A6
A7. **For female only:**				
• Are you pregnant?				A7a
• Have you given birth/ had an abortion in the last 12 months?				A7b
• Have you ever received treatment for infertility?				A7c

HIV/ AIDS, Hepatitis B and Hepatitis C Infection Risk Assessment	YES	NO	Staff Use	
B1. Have you been diagnosed of or suspected to have the following?				
• HIV infection/ AIDS				B1a
• Hepatitis B infection				B1b
• Hepatitis C infection				B1c
B2. Have you ever taken any medication to **treat** HIV infection/ AIDS?				B2
B3. **In the past 6 months**, have you				
• had tattoo, acupuncture, ear or body piercing, or accidental needle stick injury? *Tattoo includes permanent and semi-permanent cosmetic tattoos, such as microblading of eyebrows, eyelines and lips etc.*				B3a
• received blood transfusion?				B3b
• taken any medication to **prevent** HIV infection/ AIDS? *Medication includes pre-exposure prophylaxis (PrEP) and/ or post-exposure prophylaxis (PEP).*				B3c
• used or injected yourself with narcotics or non-prescribed medication?				B3d
B4. The questions below are related to your sexual contact. *Sexual contact refers to oral, vaginal or anal sex, with or without the use of condom.* **In the past 6 months**, have you				
• had sex with someone who had been diagnosed of HIV infection/ AIDS?				B4a
• taken money or drug for sex?				B4b
• had sex with someone who had taken money or drug for sex?				B4c
• had sex with someone who had used or injected narcotics or non-prescribed medication?				B4d
• **For male only:** had sexual contact with another man?				B4e
• **For female only:** had sexual contact with a bisexual man (one who has sexual contact with another man)?				B4f

CJD and vCJD (Mad-cow Disease) Infection Risk Assessment	YES	NO	Staff Use	
C1. **Between 1 January 1980 and 31 December 1996,** • have you spent a total of three or more months in the UK?				C1
C2. **Between 1 January 1980 and 31 December 2001,** • have you spent a total of five or more years in France or Ireland?				C2
C3. **Between 1 January 1980 and the present,** • have you received blood transfusion in the UK, France or Ireland?				C3
C4. Have you				
• ever received pituitary derived human growth hormone or human gonadotrophin?				C4a
• ever received organ or tissue transplant?				C4b

Other Recent Infection or Vaccination Risk Assessment	YES	NO	Staff Use	
D1. **In the past 1 week,** have you had any dental procedure (including scaling, dental extraction, etc.), open wounds or skin lesions?				D1
D2. **In the past 2 weeks,** have you had symptoms of flu, fever, headache, eye pain, muscle or joint pain, vomiting, enlarged lymph nodes or skin rash?				D2
D3. **In the past 4 weeks,** have you				
• had contact with someone with an infectious disease e.g. chickenpox, rubella, tuberculosis (TB)?				D3a
• had any vaccinations e.g. vaccination against Hepatitis A, Hepatitis B or tetanus?				D3b
• have you had diarrhea?				D3c
D4. **In the past 3 months**, have you travelled outside Hong Kong? If yes, please specify Destination(s): _____ Date of return to HK (DD/MM/YY): _____				D4
D5. **In the past 12 months,** have you				
• been bitten by any animal?				D5a
• undergone surgical operation (including endoscopic examination, treatment involving the use of catheters)?				D5b
D6. Have you been diagnosed of the following infectious diseases?				
• Malaria				D6a
• Venereal disease				D6b
• Tuberculosis (TB)				D6c
• Glandular Fever				D6d
• Dengue Fever				D6e
• West Nile Virus infection				D6f
• Chikungunya				D6g
• Others, please specify:_____				D6h

Other Risk Factors Assessment	YES	NO	Staff Use	
E1. Have you ever donated blood under another name?				E1
E2. Have you ever been informed not to donate blood permanently by us or other blood service?				E2
E3. Have you ever been resided outside Hong Kong consecutively for 5 years or longer? If yes, please specify Your previous country of residence:_____ Period: _____				E3
E4. Will you be undertaking any hazardous sport today? e.g. rock climbing, diving or flying				E4
E5. Will you be driving a heavy vehicle or working at hazardous depths or heights today? e.g. fireman, train or lorry driver, or scaffolding worker				E5

Question for Female Apheresis Donor Only	YES	NO	Staff Use	
F1. Have you ever given birth/ had an abortion?				F1

PART III: DECLARATION

I solemnly and sincerely declare that I have read, understood and agreed with **'Part I : PRE-DONATION INFORMATION'** and the staff on duty has answered all my queries.

I solemnly and sincerely declare that all information which I have provided in **'Part II : HEALTH SCREENING AND INFECTION RISK ASSESSMENT'** is true. I also consent to have my blood tested for infectious diseases (including HIV) by the Hong Kong Red Cross Blood Transfusion Service and to be informed if my blood is tested positive.

Donor Signature: _____ Date: _____

(Please sign in front of screening nurse)

Verified by
Screening Nurse
Name and Signature: _____

PART IV : PERSONAL INFORMATION

(Corresponds to Personal Identity Document) (Remark: Photocopy of form is not accepted)
If there is no change of contact details, previous donors are required to fill in items with * asterisk only.

DIN

*Name _____
Surname Other Name

Name in Chinese _____ (if applicable)

Telegraph code (_____)(_____)(_____)(_____) (if applicable)

*HK ID. No. _____ (____)

*Date of Birth _____ (DD) _____ (MM) _____ (YY)

*Sex _____

*Weight _____ (kg)

*Height _____ (cm)

Blood Group _____ (if known)

Donor ID. _____

Have you donated blood in HK Yes ☐ No ☐

*Last Donation Date _____

Corresponding Address _____
(Please provide accurate address for future correspondence)

H.K. ☐ KLN. ☐ N.T. ☐

Daytime Tel. No. _____ Nighttime Tel. No. _____

*Mobile No. _____

Email Address _____

Donor Label or For Apheresis only

HCT (%) : _____
PLT (10^3/uL) : _____
WBC (10^3/uL) : _____
Specimen collected by : _____
Staff Code: _____

I do not wish to receive information relating to the publicity and promotion of blood donation activities via ☐ Email and/ or ☐ SMS.

Unique Visit No.

☐ Put a ✓ in the appropriate box
* Circle where appropriate

Blood Pack Lot No.

Donor Examination

Hb/CBC Test Performed By: _____ Staff Code: _____ BP _____ mmHg P _____ /min

Hb/Counter Reading _____ / _____ g/dL (Highlight heading when out of range) Temp _____ °C

Hb/Counter Eq. No. EIHMC: _____ EIAUA: _____

Time Hb/CBC tested ____:____ hr.:min.

Blood Unit Weigher Equipment No. : EIMIX _____ / EICPP _____

Hand Held Sealer Equipment No. : EITCS _____

No. of DIN Labels Used / Destroyed : _____ / _____

Apheresis

C - Plasma only ☐
P - Plasma & Platelet ☐
B - Platelet only ☐

2% Lignocaine Injection

0.2ml ☐ 0.5ml ☐ **S.C.**

	(1st)	(2nd)
Time		
Signature		
Staff code		

For Official Use Only

Drive ID : _____

Remarks

Require new card ☐
I - Autologous Donation ☐
R - Directed Donation ☐

Doctor's Choice

Iron 50mg and Vitamin C 250mg / tablet
One tablet daily

☐ 15 tablets / 30 tablets*
☐ Trial - 30 tablets / 60 tablets*
☐ THAL Tx / Tx* - 60 tablets

Dispensed By _____
Staff Code _____

Blood Flow

Start Time ____:____ hr.:min.
End Time ____:____ hr.:min.
Duration _____ min.

Blood Pack (WB Donation)

Quadruple 450 ☐
Quadruple 350 ☐

Volume Collected

O - Over Collection ____ml ☐
L - Low Volume Unit ____ml ☐
I - Inadequate Collection ____ml ☐
4 - Difficult Draw ____ml ☐

Special Message:

Health Screened By:	Staff Code:	Access for Venepuncture:	Lt / Rt * (1st)	Lt / Rt * (2nd)		(1st)	(2nd)
Remark Code:	Start Date:	Accepted for Donation and Venepuncture By:			Staff Code:		
		Venepuncture Completed By:			Staff Code:		
Question No. & Deferral Code:	Start Date:	Comment:			Staff Code:		