NATIONAL BLOOD TRANSFUSION SERVICE

Donation Number

Clinic Venue --------------------------- **Clinic Code:** ------------------- **Donor Number** -----------------------

DONOR REGISTRATION FORM (Donors please complete this section below)

Surname: ____________________**Other Names**: ______________ ________________ _____________

Student Number/ National ID Number: ___________________ **Date of Birth:** / / **Sex:** F/M

Marital Status:

Single	Married	Divorced/Separated	Widowed

Contact Details: Postal Address (where you would like to receive your correspondence)

Code

Home phone number: -------------------------------------- **Cell phone number:** -------------------------------------

Email: --

Level of education: None/ Primary/ Secondary/ Tertiary **Occupation: …………………………..…**

When did you last donate Blood? ………………………….. **Blood Group: ……………………...…**

HEALTH QUESTIONNAIRE

Circle the appropriate answer

1. Are you feeling well and in good health today?	Yes/No
2. Have you eaten in the last 6 hours?	Yes/No
3. Have you ever fainted?	Yes/No
In the past 6 months have you:	
4. Been ill, received any treatment or any medication?	Yes/No
5. Had any injections or vaccinations (immunizations)?	Yes/No
6. Female Donors: Have you been pregnant or breast feeding?	Yes/No
In the past 12 months have you:	
7. Received a blood transfusion or any blood products?	Yes/No
Do you have or have you ever had:	
8. Any problems with your heart or lungs e.g. asthma?	Yes/No
9. A bleeding condition or a blood disease?	Yes/No
10. Any type of cancer?	Yes/No
11. Diabetes, epilepsy or TB?	Yes/No
12. Any other long term illness Please Specify	Yes/No

RISK ASSESSMENT QUESTIONNAIRE

The lives of patients who receive your blood are totally dependent on your honesty & frankness in answering the questions below. Your answers will be treated in a confidential manner.

Circle the appropriate answer

In the past 12 months have you:	
1. Received or given money, goods or favours in exchange for sexual activities?	Yes/No
2. Had sexual activity with a person whose background you do not know?	Yes/No
3. Been raped or sodomized?	Yes/No
4. Had a stab wound or had an accidental needle stick injury e.g. injection needle?	Yes/No
5. Had any tattooing or body piercing e.g. ear piercing?	Yes/No
6. Had a sexually transmitted disease (STD)?	Yes/No
7. Live with or had sexual contact with someone with yellow eyes or yellow skin?	Yes/No
8. Had sexual activity with anyone besides your regular sex partner?	Yes/No
Have you ever:	
9. Had yellow eyes or yellow skin?	Yes/No
10. Injected yourself or been injected, besides in a health facility?	Yes/No
11. Used non medical drugs such as Marijuana, Cocaine etc?	Yes/No
12. Have you or your partner been tested for HIV?	Yes/No
13. **Do you consider your blood safe to transfuse to a patient?**	Yes/No

DECLARATION

I declare that the information I have given above is correct.
I understand that my blood will be tested for HIV, Hepatitis B & C, and Syphilis and the results of my tests may be obtained from the National Blood Transfusion Service.
I understand that the Kenya National Blood Transfusion Service may use any communication medium(s) to send me important information. Such medium(s) shall include but not limited to e-mail, post office, mobile telephone and/or fixed telephone. I hereby give consent to KNBTS to use the contact details provided in this form to communicate to me as the need may be.

Signature: --- Date: ---

For Official Use:

Weight (kg)	**Hb >12.5g/dl**	**BP**	**Pulse**

Donor is Accepted	
Yes	**No**

Low Volume	**> 1 Venepuncture**	**Haematoma**	**Faint**		
			Mild	**Moderate**	**Severe**

Time Needle In		**Time Needle Out**	

Report:

Name of Interviewer: **Date:**