

DONOR SHEET
Tennessee Blood Services Corporation
807 Poplar Ave
Memphis, TN 38105

Medication Use

Name **Bleed Number** Bleed Date SSN Sec. ID#:

Race Sex Age D.O.B. # of Visits

Address City State Zip Last Donation Date

Occupation Telephone Bag Lot Exp.# Smoker

Temp Pulse BP Height Weight (Previous) Scale No.

Examiner Venipuncture By Time GMS Coll. MCV (Previous) Bunk No.

Prepared By Reviewed By Filed By Arm Inspection Last Food HCT

Comments

Other

ABO Rh Phenotype Antiscreen

HBsAg HCV HIV STS

NATH NATC NATB

Reagent Donor: | Non-RBC Rg Donor: | Sickle Cell:

A	D	C	c	E	e	C ^w	K	k	Le ^a	Le ^b	M	N	P ₁	Fy ^a	Fy ^b		
S	s	U	V	J _s ^a	J _s ^b	Lu ^a	Lu ^b	Kp ^a	Kp ^b	Go ^a	He	JK ^a	JK ^b	Wr ^a	Di ^a		

I have read and had explanation of reactions and care to needle site. I release Tennessee Blood Services and all persons servicing said Blood Services in any capacity from all liability due to any accident during or following the donation of this blood. I certify that I feel no symptoms which I have not mentioned to the service center personnel and am leaving (with consent) (against the advice of) the person in charge.

Donor Signature: _____ Date: _____

(OFC: Time: _____ Initials: _____)

I have reviewed and understand the information provided to me regarding the spread of the AIDS virus by donated blood or plasma and, if I consider myself a person to be at risk for spreading the virus known to cause AIDS, I agree not to donate blood or plasma for transfusion to another person or for further manufacture. I understand that my blood will be tested for antibodies and other disease markers. If this testing indicates that I should no longer give blood or plasma because of a risk of transmitting the AIDS virus, my name will be entered on a list of permanently deferred donors. I understand that I will be notified of a positive result. If, instead, the result of the testing is not clearly negative or positive, my blood will not be used and my name may be placed on a deferral list without my being informed. All information given is correct and I give my permission to have blood drawn to be used as Tennessee Blood Services deems fit. I also understand that Tennessee Blood Services will report any abnormal test results to any agency that requires them to do so.

Donor Signature: _____ Date: _____

R=REACTIVE; NR=NON-REACTIVE; POS=POSITIVE; NEG=NEGATIVE

Edward Scott, M.D.

Attachment 1 (Donor Sheet), PC10-14, Effective Date: 9/22/2010

Blood Donor Medical History

- 1 Are you in good health and feeling well today?
- 2 Have you donated blood or blood products in the past 8 weeks?
- 3 Have you been deferred as a blood donor or had problems donating?
- 4 Have you traveled out of the United States in the past three (3) years or immigrated to the U.S.?
- 5 Have you had the following: doctor's care, serious illness, major surgery or hospitalization in the past twelve (12) months?
- 6 Had a dura mater (brain tissue) or corneal transplant?
- 7 Has anyone in your family (including all blood relatives) ever had Creutzfeldt-Jacob Disease (CJD) or spent a total of three (3) months in England, Scotland, Wales, Northern Ireland, Isle of Man, or Channel Islands between 1980-1996?
- 9 Transfusion of blood or blood products in the last twelve (12) months?
- 10 Hepatitis, Yellow Jaundice, or Positive Hepatitis tests?
- 11 Exposure to Hepatitis in the last twelve (12) months, received Hepatitis B Immune-Globulin in the last twelve (12) months?
- 12 Positive HIV Test or exposure to a patient with AIDS?
- 13 Tattoos, pierced ears, acupuncture, accidental needle stick, or skin piercing in the past twelve months (12)?
- 14 Malaria, immigrated from another country, or received anti-malarial treatment in the last three (3) years?
- 15 In the past month taken any medications? Ever taken these drugs: Pituitary Growth Hormone, Accutane, Tegison, Soriatan, Proscar, Propeda, and/or Avodart?
- 16 Addicted to or under the influence of drugs or alcohol?
- 17 Heart disease, high blood pressure, chest pain, or shortness of breath?
- 18 Lung disease, chronic cough, emphysema, or tuberculosis?
- 19 Blood disease, bleeding abnormalities, or hemophilia?
- 20 Tumor or cancer other than minor skin cancer?
- 21 After infancy: Any convulsions, seizures, fainting spells, or epilepsy?
- 22 Kidney or liver disease, ulcers, or diabetes requiring insulin?
- 23 Vaccinations, immunizations, or shots in the last twelve (12) months?
- 24 Active allergy, cold, or infection, contact with contagious disease?
- 25 Treatment of Syphilis, Gonorrhea (Clap), or any other Venereal Disease in the last twelve (12) months?
- 26 Had unexpected night sweats, fever or weightloss? Lumps in neck, armpits, or groin? Discolored areas of skin or mouth? Persistent cough or diarrhea?
- 27 Pink or purple blotches anywhere on skin or mucus membranes?
- 28 White spots or blemishes in the mouth?
- 29 If male, have ever participated in a sex act with another male since 1977 even one time or been the heterosexual partner of a prostitute in the last twelve (12) months?
- 30 Engaged in sex for drugs or money since 1977?
- 31 Sex partner of any of the above (high-risk group)?
- 32 Have ever had sex with anyone who has AIDS or has had a positive test for AIDS virus in the last twelve (12) months?
- 34 Have you ever taken illegal drugs with a needle, even one time or had sex with anyone who has in the last twelve (12) months?
- 35 Have you taken clotting factor concentrates for a bleeding disorder such as Hemophilia or had sex with anyone who has in the past twelve(12) months?
- 36 Have you been in jail or prison for seventy-two (72) hours or more in the past twelve (12) months?
- 37 A. Were you born in, or have you lived in, or have you traveled to any African countries since 1977; (If yes, ask question 38; if no goto 39)
- 38 B. Did you receive a blood transfusion or any medical treatment with a product made from blood while you were in that country?
- 39 C. Have you had sex with anyone who was born in, lived in, or traveled to any of these countries?
- 40 Were you provided with AIDS and Health Information Pamphlets?
- 41 Do you have any questions concerning the AIDS and Health Information Pamphlets?
- 42 Do you understand the AIDS and Health Information Pamphlets?
- 43 A. In the past twenty-eight (28) days, have you been ill with SARS or suspected SARS?
- 44 B. In the past fourteen (14) days, have you cared for, lived with, or had direct contact with body fluids of a person with SARS or suspected SARS?
- 45 C. In the past fourteen (14) days, have you traveled to, traveled through, or resided in areas affected by SARS?
- 46 In the past week, have you had a fever with headache?
- 47 A. In the past eight (8) weeks, have you received a Smallpox vaccination?
- 48 B. Has the Smallpox vaccination scab fallen off your skin by itself?
- 49 C. Did you have any illness or complications due to the Smallpox vaccination?
- 50 D. In the past eight (8) weeks, have you had close contact with the Smallpox vaccination site of anyone else?
- 51 E. Have you had any new skin rash or skin sore since the time of contact with the Smallpox vaccination site?
- 52 Do you feel that your blood would be safe for transfusion and/or other manufacturing?

The donation procedure and possible side effects have been explained to me and I have been given the chance to ask any question regarding the procedure. To the best of my knowledge the above history is correct. This donation is made voluntarily and the blood and derivatives may be used in a manner decided by Tennessee Blood Services Corp or any affiliated medical facility. I expressly authorize circulation of all information pertaining to this donation at the discretion of Tennessee Blood Services Corp or its agents. I also understand that my blood may be used in research studies at the discretion of Tennessee Blood Services Corp or its agents. There will be no information provided for these research studies that identifies myself. Therefore, I understand that no results from this research testing can be given to me. I have answered the above questions to the best of my knowledge and certify that I have not given blood within the past eight (8) weeks. I understand the procedure and possible adverse reactions in donating blood. I have been informed about AIDS and the HIV test. I do not have cause for deferral due to this test or syndrome.

Donor Signature: _____ Date: _____

Historian Signature: _____ Date: _____