

Donor Screening Card

DeGowin Blood Center – Department of Pathology - University of Iowa Hospitals and Clinics

Office Use Only					
Mobile Donor ID	Mobile Visit ID	New to DeGowin <input type="checkbox"/> Y <input type="checkbox"/> N	Visit Date		
Donor ID	Donor Visit ID	Group Code			
Name (Last, First, MI)			Date of Birth		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	State	Zip	
Phone Number (Check One) <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Business		Phone Number (Check One) <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Business			
Email				<input type="checkbox"/> Yes <input type="checkbox"/> No First Donation	
Apheresis Only					
Predict Values	TBV:	Platelet – Need to Ct WBC: Y N		RBC – Need to Ct WBC: Y N	
PLT: _____	Platelet Vol: _____	Plasma Vol: _____	RBC #1 Vol: _____	RBC #2 Vol: _____	Total Vol: _____
PLS: _____	AC: _____	AC: _____	AC: _____	AC: _____	AC: _____
RBC 1: _____	RBC Bag #1 RBC Vol: _____		RBC Bag #2 RBC Vol: _____		Unit # Barcode
RBC 2: _____	Hgb Conc: _____		Hgb Conc: _____		
	QC Acceptable? Y N		QC Acceptable? Y N		
Date Drawn: _____		Record Reviewer: _____		WB Processed:	
Screener: _____		Peer Reviewer: _____			

	Yes	No
Are you		
1. Feeling healthy and well today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Currently taking an antibiotic?	<input type="checkbox"/>	<input type="checkbox"/>
3. Currently taking any other medication for an infection?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you taken any medications on the Medication Deferral List in the time frames indicated? (Review the Medication Deferral List.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you read the educational materials today?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 48 hours,		
6. Have you taken aspirin or anything that has aspirin in it?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 8 weeks, have you		
7. Donated blood, platelets or plasma?	<input type="checkbox"/>	<input type="checkbox"/>
8. Had any vaccinations or other shots?	<input type="checkbox"/>	<input type="checkbox"/>
9. Had contact with someone who was vaccinated for smallpox in the past 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 3 months, have you		
10. Had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
11. Had a transplant such as organ, tissue, or bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>
12. Had a graft such as bone or skin?	<input type="checkbox"/>	<input type="checkbox"/>
13. Come into contact with someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>
14. Had an accidental needle-stick?	<input type="checkbox"/>	<input type="checkbox"/>
15. Had sexual contact with anyone who has ever had HIV/AIDS or has ever had a positive test for the HIV/AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had sexual contact with a prostitute or anyone else who has ever taken money or drugs or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
17. Had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything <u>not</u> prescribed by their doctor?	<input type="checkbox"/>	<input type="checkbox"/>
18. Male donors: Had sexual contact with another male?	<input type="checkbox"/>	NO <input type="checkbox"/> NA <input type="checkbox"/>
19. Female donors: Had sexual contact with a male who had sexual contact with another male in the past 3 months?	<input type="checkbox"/>	NO <input type="checkbox"/> NA <input type="checkbox"/>
20. Had a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had ear or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had or been treated for syphilis or gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>
23. Used needles to take drugs, steroids, or anything <u>not</u> prescribed by your doctor?	<input type="checkbox"/>	<input type="checkbox"/>
24. Received money, drugs, or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>

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In the past 16 weeks , have you			
25. Donated a double unit of red cells using an apheresis machine?	<input type="checkbox"/>	<input type="checkbox"/>	
In the past 12 months , have you			
26. Had sexual contact with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Lived with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	
28. Been in juvenile detention, lockup, jail or prison for 72 hours or more consecutively?	<input type="checkbox"/>	<input type="checkbox"/>	
In the past 3 years , have you			
29. Been outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you EVER			
30. Female donors: been pregnant or are you pregnant now?	<input type="checkbox"/>	NO <input type="checkbox"/>	NA <input type="checkbox"/>
31. Had a positive test for the HIV/AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	
32. Had malaria?	<input type="checkbox"/>	<input type="checkbox"/>	
33. Received a dura mater (or brain covering) graft or xenotransplantation product?	<input type="checkbox"/>	<input type="checkbox"/>	
34. Had any type of cancer, including leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	
35. Had any problems with your heart or lungs?	<input type="checkbox"/>	<input type="checkbox"/>	
36. Had a bleeding condition or a blood disease?	<input type="checkbox"/>	<input type="checkbox"/>	
37. Had a positive test result for Babesia?	<input type="checkbox"/>	<input type="checkbox"/>	
38. In the past 3 months , have you taken any medication to prevent HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	
39. Have you EVER taken any medication to treat an HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	
40. Have you EVER had a splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>	
41. Female Donors: When was your last pregnancy? Month _____ Year _____			

I have read and have been given the opportunity to discuss information provided by the DeGowin Blood Center regarding the risks of infection that might be transmitted by blood. I understand this information and agree not to donate blood products if I know that I have any of these infections such as AIDS or hepatitis—OR if I believe that I may have been exposed to these infections. I certify that I have provided accurate information about my health and medical history. I have read the DONOR INFORMATION SHEET and understand that my blood will be tested for evidence of infections such as AIDS, hepatitis, syphilis and other infections and that some of the testing will be used for research purposes. If positive, I will be advised of the implications of the test result and my name will be entered on a permanently deferred list. Attempts will be made to ensure confidentiality, but it is necessary that designated personnel know the results and keep records. When required by law or regulations, positive test results will be reported to the Health Department.

I understand that under certain circumstances infectious disease testing cannot be performed. The Food and Drug Administration and other regulatory agencies with oversight for blood donor facilities may view donor information for purposes of compliance auditing, but would not receive copies that contain any personal identifying information. **I understand I should withdraw myself from the donation process if I feel my blood is not suitable for donation.** I am voluntarily donating blood to the University of Iowa Hospitals and Clinics to be used as decided by the institution. The risks of phlebotomy have been explained to me and I have had an opportunity to have my questions answered.

Signature: _____ Date: _____

Comments: _____

Unit #