

Donor ID: an_gridformatted

Date: 17/06/2024

Donor Name: fullname

1	What is your current living situation? Do you live by yourself or with other people?		
2	Are you currently employed or studying?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Do you have any allergies? If yes, please list:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Inform TC if relevant	
4	Have you had any immunisations / vaccinations in the last eight weeks ? Do you have plans to receive any before your donation? If yes, what/when?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Check vaccination type (e.g. live). Inform TC, if live defer	
5	Have you ever been pregnant (including miscarriages/terminations)? If yes, how many times?..... How many live births?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6	Is there any possibility you could be pregnant now? Date of beginning of last menstrual period.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7	Has any first degree relative (parent, sibling, child) been diagnosed with a blood cancer or any other blood disorder? If yes, please provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Inform TC	
8	Have you received a transfusion of blood, platelets or other blood product since 1980 ? If yes, when and where.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Inform TC	
9	Are you a blood donor? If yes, when was the last time you donated blood?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10	Have you ever had a bleeding problem, such as haemophilia or other clotting factor deficiencies and received blood products/clotting factor concentrates? If yes, please provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Defer	
11	Have you ever been diagnosed with Creutzfeldt-Jakob-Disease (CJD), or do you have a degenerative neurological disease? If yes, please provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Defer	
12	Has anyone in your family had CJD, or have you been told that your family has an increased risk for CJD?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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	If yes, please provide details	Inform TC	
13	Have you had brain surgery or an operation for a tumour or cyst on the spine prior to August 1992? If yes, please provide details	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
14	Have you ever received a corneal transplant, or had any other operations on your eyes? If yes, please provide details	Yes <input type="checkbox"/> Obtain details re: use of scleral/other ocular tissue grafts	No <input type="checkbox"/>
15	Have you ever received a xenograft transplant (a surgical graft of tissue from one species to an unlike species)? If yes, please provide details	Yes <input type="checkbox"/> Defer	No <input type="checkbox"/>
16	Have you ever been treated with human pituitary extracts such as growth hormones prior to 1985? If yes, please provide details	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
17	Have you ever had yellow jaundice, liver disease or hepatitis (except for jaundice as a young baby)? If yes, please provide details	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
18	Have you ever suffered from a head injury? If no go to Q19 (next question). If yes, please provide details of when and what type	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Have you suffered from more than 3 concussions in your lifetime? If yes, were there more than 6?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Did you lose consciousness for more than 5 minutes? If yes, was it more than 1 hour?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Post injury have you suffered from any of the following symptoms that lasted more than 72 hours: short term memory loss, blurred vision, light or noise sensitivity, nausea or vomiting, dizziness or balance problems, difficulty thinking, poor concentration, seizure, personality changes, severe headache? If yes, please provide more details.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19	Are you or have you been in any type of therapy? This can include physiotherapy, cognitive behavioural therapy, counselling therapy etc. If so, what type and when?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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20	Do you, or have you ever suffered from a mental health condition or disorder in relation to:															
a	Anxiety (including panic disorder, obsessive compulsive disorder- OCD and post-traumatic stress disorder- PTSD)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
b	Eating (including anorexia and bulimia nervosa)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
c	Mood (including depression and bipolar disorder)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
d	Personality (including borderline personality disorder)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
e	Substance abuse? If yes, please specify:.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
f	Schizophrenia and other Psychotic Disorders (including schizoaffective and delusional disorder)	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
21	Are there any issues in your life that have required extra attention in the past 12 months? If yes, do you mind providing some detail about it? 	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
22	Have you travelled outside the UK and Ireland in the last 12 months? Please give all destinations with month and year of travel below 	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
<p>NOTES FOR ASSESSING CLINICIAN</p> <p>For endemic areas and high-risk season for <u>each</u> country visited refer to geographical disease risk index (www.transfusionguidelines.org).</p> <p>If testing is required but results cannot be obtained in time donor can proceed at TC's discretion.</p> <p>Malaria</p> <p><u>All</u> visitors to endemic areas within the last 12 months should be tested, regardless of prophylaxis.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Status</th> <th colspan="2">Action</th> </tr> </thead> <tbody> <tr> <td rowspan="3" style="text-align: center;">Visitor</td> <td style="text-align: center;"><4 months since return</td> <td>Request MAT and NAT</td> </tr> <tr> <td style="text-align: center;">4-12 months since return</td> <td>Request MAT</td> </tr> <tr> <td style="text-align: center;">>12 months since return</td> <td>Accept, No test</td> </tr> <tr> <td style="text-align: center;">Resident</td> <td style="text-align: center;"><4 months since last exposure</td> <td>Request MAT and NAT</td> </tr> </tbody> </table>		Status	Action		Visitor	<4 months since return	Request MAT and NAT	4-12 months since return	Request MAT	>12 months since return	Accept, No test	Resident	<4 months since last exposure	Request MAT and NAT		
Status	Action															
Visitor	<4 months since return	Request MAT and NAT														
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	<table border="1"> <tr> <td>Lived in a malaria area > 6 continuous months at any point in their life</td> <td>>4 months since last exposure</td> <td>Request MAT</td> </tr> <tr> <td>UFI</td> <td><4 months since last exposure</td> <td>Request MAT and NAT</td> </tr> <tr> <td>Unexplained febrile illness</td> <td>>4 months since last exposure</td> <td>Request MAT</td> </tr> <tr> <td rowspan="2">History of Malaria</td> <td><4 months since recovery</td> <td>Request MAT and NAT</td> </tr> <tr> <td>>4 months since recovery</td> <td>Request MAT</td> </tr> </table> <p>West Nile Virus Accept <u>without</u> testing: - Visitors to endemic areas outside of high-risk season - Visitors to endemic areas during high risk season who returned to the UK over 28 days ago and had neither symptoms nor evidence of WNV infection while abroad or since return</p> <p>WNV NAT should be tested in the following instances: - Visitors to endemic areas during high risk season (See Geographical Disease Risk Index) who have returned to the UK in last 28 days - Visitors to endemic areas during high risk season (See Geographical Disease Risk Index) who have returned to the UK within last six months and had symptoms suggestive of WNV while abroad or within 28 days of return</p> <p>Tropical Viruses – Dengue Virus, Chikungunya, Zika Virus Accept <u>without</u> testing: - Visitors to endemic areas who have returned to the UK over 28 days ago and had neither symptoms nor evidence suggestive of Chikungunya, Dengue or Zika virus infection while abroad or since return</p> <p>NAT should be tested in the following instances: - Visitors to endemic areas who have returned to the UK in last 28 days - Visitors to endemic areas who have returned to the UK within last six months and had symptoms or evidence of Dengue, Chikungunya or Zika virus infection while abroad or within 28 days of return</p> <p>T. Cruzi (American Trypanosomiasis / Chagas' Disease See Qs 29-31</p>	Lived in a malaria area > 6 continuous months at any point in their life	>4 months since last exposure	Request MAT	UFI	<4 months since last exposure	Request MAT and NAT	Unexplained febrile illness	>4 months since last exposure	Request MAT	History of Malaria	<4 months since recovery	Request MAT and NAT	>4 months since recovery	Request MAT		
Lived in a malaria area > 6 continuous months at any point in their life	>4 months since last exposure	Request MAT															
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Unexplained febrile illness	>4 months since last exposure	Request MAT															
History of Malaria	<4 months since recovery	Request MAT and NAT															
	>4 months since recovery	Request MAT															
23	<p>Do you have plans to travel outside the UK and Ireland between now and your donation date? If yes, where and when?</p> <p>.....</p> <p>.</p> <p>.....</p> <p>.</p>	Yes <input type="checkbox"/> Consult Geographical Disease Risk Index	No <input type="checkbox"/>														
24	<p>Have you ever been diagnosed with West Nile Virus? If yes, when</p> <p>.....</p> <p>.</p>	Yes <input type="checkbox"/> Test WNV NAT if within last four months. Inform TC	No <input type="checkbox"/>														

	Zika Virus Q25 - Please notify Anthony Nolan if donor answers yes to this question. Additional testing not required.		
25	<p>Have you had sex with a male partner who had travelled or lived in a Zika virus affected area during the 3 months previous to sex? (If you are unsure about regions affected by Zika Virus please discuss with the doctor / nurse during your medical assessment)</p> <p>If yes, was the date of sex within the last 28 days?</p>	Yes <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> No <input type="checkbox"/>

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26	Have you ever had malaria, or suffered an unexplained fever during or after visiting a malaria risk area? If yes, when/where	Yes <input type="checkbox"/> Test malaria anti-bodies. Inform TC	No <input type="checkbox"/>
27	Have you lived in a malaria risk area for six or more continuous months at any time of your life? If yes, when/where	Yes <input type="checkbox"/> Test malaria anti-bodies. Inform TC	No <input type="checkbox"/>
28	Were you born, or have you ever lived, in Africa? If yes, where?.....	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
<p>T. Cruzi (American Trypanosomiasis / Chagas' Disease) Qs 30-32 All donors answering yes to any of these questions must have a T Cruzi antibody test performed. Donors who have travelled to these areas who do not answer yes to these questions <u>do not</u> need to be tested</p>			
29	Have you ever been diagnosed with South American Trypanosomiasis (Chagas) disease? If yes, please provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
30	Were you or your mother born in South America or Central America (including Mexico, excluding Cuba)? If yes, please provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
31	Have you lived and/or worked in rural farming communities in South America or Central America (including Mexico, excluding Cuba) for a continuous period of four weeks or more? If yes, please provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
32 a	Have you ever been diagnosed with Viral Haemorrhagic Fever (VHF), including Crimean-Congo Fever, Ebola, Lassa Fever, Marburg fever? If yes, please provide details	Yes <input type="checkbox"/> Defer	No <input type="checkbox"/>
b	Have you ever travelled to a VHF endemic area? e.g. Guinea, Liberia, Sierra Leone, Nigeria, etc. If yes, please provide details	Yes <input type="checkbox"/> Defer if in area during active outbreak, if not defer for six months post return	No <input type="checkbox"/>
c	Have you ever had a sexual partner diagnosed with VHF at any time before your last sexual contact? If yes, please provide details	Yes <input type="checkbox"/> Defer if partner diagnosed before last contact	No <input type="checkbox"/>
33	Have you had sex (oral, vaginal or anal) with a new partner, or more than one partner, in the last 14 days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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34	In the past three months have you had sex (oral, vaginal or anal) with:		
a	A new partner, or more than one partner? If yes, did you have anal sex?	Yes <input type="checkbox"/> Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/> No <input type="checkbox"/>
b	an individual who is HIV positive or who has ever had syphilis, hepatitis B or C or yellow jaundice?	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
c	anyone who has ever injected drugs?	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
d	an individual who has ever been given or taken money in exchange for drugs or sex?	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
35	Have you had chem sex or used drugs during sex (excluding erectile dysfunction drugs or cannabis) within the last three months ?	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
36	Have you given or taken money in exchange for drugs or sex within the last three months ? If yes, please provide details	Yes <input type="checkbox"/> Inform TC, consider deferral	No <input type="checkbox"/>
37	Have you ever taken PrEP (Pre-Exposure Prophylaxis, anti-HIV medication)? If so was it in the last 3 months ?	Yes <input type="checkbox"/> Yes <input type="checkbox"/> Defer	No <input type="checkbox"/> No <input type="checkbox"/>
38	Are you HIV positive, have you ever tested positive for HIV or do you think you may be HIV positive? If yes, please provide details	Yes <input type="checkbox"/> Defer	No <input type="checkbox"/>
39	Have you ever had hepatitis B or C, have you ever tested positive for hepatitis B or C, or do you think you may have hepatitis now? If yes, please provide details	Yes <input type="checkbox"/> Defer	No <input type="checkbox"/>
40	Have you ever tested positive for HTLV (Human T-lymphotropic virus)? If yes, when	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>
41	Within the last four months have you had an injury which could have put you at risk of hepatitis or HIV – for example a needle stick injury, coming into contact with someone else’s blood through an open wound, non-intact skin, or mucous membrane (e.g. into your eye or mouth) If yes, please provide details	Yes <input type="checkbox"/> Inform TC	No <input type="checkbox"/>

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<p>42</p>	<p>In the past 12 months have you had a confirmed positive test result or been treated for syphilis or gonorrhoea?</p> <p>If yes, when</p>	<p>Yes <input type="checkbox"/></p> <p>Inform TC</p>	<p>No <input type="checkbox"/></p>
<p>43</p>	<p>Have you ever injected or been injected with illegal or non-prescription drugs including bodybuilding drugs?</p> <p>If yes, please provide details</p>	<p>Yes <input type="checkbox"/></p> <p>Inform TC, consider deferral for 12 months</p>	<p>No <input type="checkbox"/></p>
<p>44</p>	<p>In the past three months have you undergone acupuncture in a non-UK establishment or by an unqualified practitioner?</p> <p>If yes, please provide details</p>	<p>Yes <input type="checkbox"/></p> <p>Obtain professional reg certificate if possible. Inform TC.</p>	<p>No <input type="checkbox"/></p>
<p>45</p>	<p>In the past three months have you had a tattoo (or tattoo removal), any piercing to your ears, face or body or undergone any cosmetic treatment that involved piercing the skin in a non-licensed establishment?</p> <p>If yes, please provide details</p>	<p>Yes <input type="checkbox"/></p> <p>Inform TC</p>	<p>No <input type="checkbox"/></p>
<p>46</p>	<p>In the past four months have you been detained in a prison for more than 72 continuous hours?</p> <p>If yes, please provide details</p>	<p>Yes <input type="checkbox"/></p> <p>Inform TC</p>	<p>No <input type="checkbox"/></p>
<p>47</p>	<p>Have you ever been bitten by a non-human primate? e.g. ape, lemur</p> <p>If yes, please provide details</p>	<p>Yes <input type="checkbox"/></p> <p>Defer</p>	<p>No <input type="checkbox"/></p>
<p>48</p>	<p>Have you been bitten by a bat in the last two years?</p> <p>If yes, please provide details</p>	<p>Yes <input type="checkbox"/> Defer for two years from date of bite</p>	<p>No <input type="checkbox"/></p>
<p>49</p>	<p>Have you ever been exposed to rabies?</p> <p>If yes, please provide details</p> <p>If yes, were you cleared by a Doctor/Physician?</p>	<p>Yes <input type="checkbox"/></p> <p>Defer for two years from exposure date, if medically cleared.</p>	<p>No <input type="checkbox"/></p>

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50	<p>Have you ever taken or been exposed to or ingested cyanide, lead or mercury? Have you ever ingested gold?</p> <p>If yes, please provide details</p> <p>.....</p> <p>.....</p>	Yes <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> No <input type="checkbox"/>
		Inform TC	

Covid-19 screening			
51	<p>In the past 14 days, have you had a confirmed or presumed diagnosis of COVID-19?</p> <p>If yes, when did you recover?</p> <p>Has a negative test been confirmed?</p> <p>If yes, when was this performed?</p>	Yes <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> No <input type="checkbox"/>

Please provide next of kin details here:	
Name	an_gr
Relationship to you	an_dc
Contact number	

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DONOR STATEMENT OF UNDERSTANDING

I have had the opportunity to ask questions about the information requested on the questionnaire "Donor Health History".

I understand that the requested information is important if I am at risk for infection due to HIV, Hepatitis B or C, or any other communicable disease agents or diseases, my donated cells may transmit these diseases to the patient receiving the cells.

If at any time during the donation process I develop any of the following symptoms: A cough, fever or difficulty breathing, I will contact my Donor Provision coordinator.

I have truthfully answered all the questions on this questionnaire.

I authorise the release of information on the questionnaire to the overseas Registry (which may be outside the European Union) and its agents and representatives and other medical facilities known as transplants centres. This release may only be in connection with the possibility of the donation of my blood stem cells to a patient. I understand that any information identifying me will remain confidential and only my unique donor identification number will be used on any information passed to the overseas Registry. I also understand that the potential recipient of my donation may be advised of any communicable risk.

I understand that authorising this release of information is voluntary and that I can refuse to sign this document.

Donor Details	
Name	fullname
GRID	an_gridformatted
Donor ID	an_donorinternationalregistryid
Signature	
Reviewed by	
Name	
Signature	
Job Title	
Date	

Donor Health History (MUST BE COMPLETED AT DONOR'S MEDICAL)



Saving lives through stem cells

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If the donation date has been postponed since the original medical, please complete the following:

I confirm there have been no changes to the above information provided, and I have advised the Collection Centre/AN of all health changes (if any) since my original medical

Donor name	
Signature*	
Date	

* If you are completing online and unable to insert a signature please just initial this box.