

Blood Donation Application Form

National Blood Centre, Thai Red Cross Society

<input type="checkbox"/> First Time Donor	<input type="checkbox"/> Repeat Donor	Date of Donation (dd/mm/yy).....
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Donor Age Limit :

Whole blood: 17-70 years # If 17 years old, letter of consent from parent or guardian is required.
 # If first-time donation, age must be lower than 60 years old.
 # If repeat donor who is 65-70 years old, additional health evaluation is required.

Apheresis: 17-60 years # If first-time donation, age must be lower than 50 years and have experienced in whole blood donation.

For Repeat Donors

What type of donation did you make? Whole Blood Apheresis

Apheresis, please specify: Single Donor Red Cells Single Donor Platelets Plasmapheresis Others

Complications of previous donations? No complication

Complications: Fainting Bruise Phlebotomy problem
 Not allowed to donate due to Others

CITIZEN ID / PASSPORT NUMBER

Blood Donor ID.....

Date of birth (dd/mm/yy) Ageyears Gender..... Weightkg

Present address Not changed Changed as follows:

Postal Code Telephone Mobile phone

E-mail address.....

Occupation : Student Gov. official, soldier, police or state enterprise worker Employee
 Monk, priest Agriculturist Business Others.....

Name: Mr. / Ms. / Mrs. (Please write in block letters).....
 (Given names/First name) (Surname/Last name)

Maiden name

For staff

Donor ID No. of Donations.....

For repeat donor, if donor ID card not available please fill in the followings:

First donation (dd/mm/yy)..... Place.....

Last donation (dd/mm/yy)..... Place.....

Blood pressure.....mm Hg

Pulse.....bpm normal abnormal

Heart/Lung normal abnormal

Temperature.....°c pass not pass

Hb.....g/dL pass not pass

Unit Number

Blood Group	Rh
<input type="checkbox"/> Deferred <input type="checkbox"/> On medication that affects platelet function <input type="checkbox"/> Under volume <input type="checkbox"/> High volume <input type="checkbox"/> Discarded	

Remarks

Registrar..... Blood bag preparation staff..... Blood collector.....

Blood sample collector Rechecked by.....

Blood Donor Questionnaire

For safety of donors and recipients of blood transfusion, please provide truthful answer to this questionnaire .If you are not sure that your blood is safe, please refrain from donation.

For interviewer: this form must be used according to the Document for Blood Donor Health Screening, National Blood Centre, Thai Red Cross Society.

		Yes	No			Yes	No
General health							
1. Do you feel well and healthy today?.....	<input type="checkbox"/>		<input type="checkbox"/>	22. Have you had a transplant such as organ, tissue, or stem cells?	<input type="checkbox"/>		<input type="checkbox"/>
2. Did you sleep tight last night? (for at least 5 hours of sleep)	<input type="checkbox"/>		<input type="checkbox"/>	23. In the past 12 months, have you been stuck by bloody needle?	<input type="checkbox"/>		<input type="checkbox"/>
3. Did you take fatty food within the past 6 hours?.....	<input type="checkbox"/>		<input type="checkbox"/>	24. Have you had hepatitis after age of 11 years?	<input type="checkbox"/>		<input type="checkbox"/>
4. Do you have any chronic disease or health problem? If yes, please specify.....	<input type="checkbox"/>		<input type="checkbox"/>	25. In the past 12 months, have you lived with a person who had hepatitis?	<input type="checkbox"/>		<input type="checkbox"/>
5. In the past 7 days, are you currently taking antibiotics or any medication for an infection? If yes, please specify.....	<input type="checkbox"/>		<input type="checkbox"/>	26. Have you ever been tested positive for hepatitis viruses?.....	<input type="checkbox"/>		<input type="checkbox"/>
6. In the past 48 hours, have you taken aspirin, a muscle relaxant, or pain killer? If yes, please specify.....	<input type="checkbox"/>		<input type="checkbox"/>	27. In the past 3 years, have you had malaria?	<input type="checkbox"/>		<input type="checkbox"/>
7. Do you regularly take medications, herbal medicine, or supplement food that contains biotin? If yes, please specify.....	<input type="checkbox"/>		<input type="checkbox"/>	28. In the past 12 months, have you traveled to an area with malaria?	<input type="checkbox"/>		<input type="checkbox"/>
8. In the past 24 hours, have you drunk alcohol?	<input type="checkbox"/>		<input type="checkbox"/>	29. In the past 1 month, have you had influenza, dengue, chikungunya, Zika or COVID-19? If yes, please specify.....	<input type="checkbox"/>		<input type="checkbox"/>
9. In the past 6 months, have you donated hematopoietic stem cells?..... If yes, please specify <input type="checkbox"/> bone marrow <input type="checkbox"/> peripheral blood	<input type="checkbox"/>		<input type="checkbox"/>	30. In the past 2 months, have you had any vaccination or other shots? If yes, please specify.....	<input type="checkbox"/>		<input type="checkbox"/>
Pregnancy and childbirth				31. In the past 12 months, have you had any serum injection for passive immunization?	<input type="checkbox"/>		<input type="checkbox"/>
10. Have you ever been pregnant or abortion?	<input type="checkbox"/>		<input type="checkbox"/>	32. Have you ever been intravenous drug user (IVDU)?	<input type="checkbox"/>		<input type="checkbox"/>
11. Are you currently pregnant or breast-feeding?.....	<input type="checkbox"/>		<input type="checkbox"/>	33. In the past 12 months, have you ever been imprisoned for more than 72 consecutive hours?	<input type="checkbox"/>		<input type="checkbox"/>
12. In the past 6 months, have you had given birth / abortion?.....	<input type="checkbox"/>		<input type="checkbox"/>	34. In the past 3 months, have you had weight loss, fever, enlarged lymph node without apparent cause or ever tested positive for HIV/AIDS virus?	<input type="checkbox"/>		<input type="checkbox"/>
Sexual behavior: for all genders				35. From 1980 through 1996, did you spend time that adds up to 3 months or more in the United Kingdom countries of England, Northern Ireland, Scotland and Wales?	<input type="checkbox"/>		<input type="checkbox"/>
13. Have you/your sex partner ever had sexual contact with anyone with the following characteristics? - having more than one sex partners <input type="checkbox"/> <input type="checkbox"/> - sex worker, or anyone who has ever taken payment for sex - having used illegal drugs or needle to inject non-prescribed drugs - having had a positive test for HIV/AIDS virus or other sexual transmitted diseases	<input type="checkbox"/>		<input type="checkbox"/>	36. From 1980 through 2001, did you spend time that adds up to 5 years or more in France or Ireland?	<input type="checkbox"/>		<input type="checkbox"/>
14. Have you ever taken medication for treatment or prevention of HIV infection? (PrEP or PEP)	<input type="checkbox"/>		<input type="checkbox"/>	37. Are you confident that your blood is safe for transfusion?	<input type="checkbox"/>		<input type="checkbox"/>
15. Do you have MSM (men who have sex with men) sexual behavior?	<input type="checkbox"/>		<input type="checkbox"/>	I hereby certify that my answer to the questionnaire is truthful and information given is correct.			
Conditions that might increase infection risk				I therefore voluntarily donate my blood to National Blood Centre, Thai Red Cross Society, for the benefit of transfusion service and medical research*.I acknowledged that my blood donation will be subjected to testing for syphilis, hepatitis B and C, and HIV viruses before it is used for medical purposes. In addition, I was also informed that it could be manufactured for medicinal products which will be distributed to the hospitals for therapeutic use.			
16. Have you had any dental procedure including tooth filling, plaque removal in the past 3 days, or tooth extraction or root canal treatment in the past 7 days?	<input type="checkbox"/>		<input type="checkbox"/>	I am confident that my blood is safe for transfusion.			
17. Have you had diarrhea in the past 7 days?	<input type="checkbox"/>		<input type="checkbox"/>	I have been informed of benefits and risks associated with blood donation and I am willing to donate blood.			
18. In the past 4 months, have you had ear or body piercings, tattoo or tattoo removal, or acupuncture?	<input type="checkbox"/>		<input type="checkbox"/>	I accepted the purposes for collecting, processing, using and disclosing the personal data for medical researches and blood services.			
19. In the past 7 days, have you had any minor surgery?.....	<input type="checkbox"/>		<input type="checkbox"/>	Signature.....Date.....			
20. In the past 6 months, have you had any major surgery?	<input type="checkbox"/>		<input type="checkbox"/>	* Medical research for public interest that has been approved by research ethic committee of National blood centre or related organization (in accordance with the Thai Medical Council regulation on research and experiments on human subjects, BE 2525), or research project that will be announced.			
21. In the past 12 months, have ever been sick and received any blood transfusion?.....	<input type="checkbox"/>		<input type="checkbox"/>	Staff note (optional)			
				Signature of doctor/ staff			