

Spenderaufkleber

Name, Vorname:

Geburtsdatum:

Anschrift (PLZ/Ort/Straße)

Telefon-Nr. privat/berufl.

Die Identität des Spenders wurde durch Vorlage eines gültigen amtlichen Dokumentes mit Lichtbild gesichert. ☐

Temperatur: _____

Gesamteindruck: ☐ opB ☐ _____

Gewicht: _____

Körpergröße _____

RR: _____ / _____

Puls: _____/min

HB-Wert: _____

Dear blood donor,

Thank you for your visit and your willingness to enable the supply of vital blood products to patients! As part of your donation, blood samples will be taken to test for any abnormalities or illnesses. We are obliged to use at least 1% of blood donations for quality control. We would like to ask you to read this questionnaire carefully. For your protection and that of the recipient, all questions must be answered to the best of your knowledge and belief. If you are unsure about the correct answer, please ask the doctor responsible for the blood donation.

WE WISH YOU A PLEASANT DONATION!

YOUR BLOOD DONATION TEAM

Questions on your general state of health			
1.	<ul style="list-style-type: none"> Do you feel unwell/ill today on the donation day or are you currently on sick leave? Have you already eaten and drunk something today? Do you weigh at least 50 kg? 	<input type="checkbox"/> yes <input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no <input type="checkbox"/> no
2.	In the last 7 days, have you had <ul style="list-style-type: none"> An uncomplicated infection without an elevated temperature (e.g., a cold or urinary tract infection)? A dental treatment or professional dental cleaning? 	<input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no
3.	In the last 4 weeks, have you had diarrhoea, a persistent stomachache, vomiting, signs of inflammation, or a temperature at any time?	<input type="checkbox"/> yes	<input type="checkbox"/> no
4.	In the last 4 months, have you been under medical / alternative medical treatment or been to a hospital?	<input type="checkbox"/> yes	<input type="checkbox"/> no
5.	Do you have or have you ever had one or more of the following medical conditions? (Please <u>underline</u> if applicable): <ul style="list-style-type: none"> Heart or vascular disease (such as thrombosis, heart attack, irregular heartbeat, stroke)? Neurological disease (such as epilepsy)? Repeated fainting fits? Diseases of skin, blood, lung (e. g. asthma), liver, kidney, stomach, or intestine? Chronic diseases like allergies, diabetes, alcohol disease? Tumour (for example, cancer)? 	<input type="checkbox"/> yes	<input type="checkbox"/> no

6.	<ul style="list-style-type: none"> Have you been told before that you may not donate blood or plasma? Have you ever experienced complications in connection with any donation? Do you also donate blood in other institutions? 	<input type="checkbox"/> yes <input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no <input type="checkbox"/> no
7.	In the 12 hours after your donation, will you engage in activities that have the potential to harm yourself or others (such as transporting people, activities with a risk of falling, or activities involving strenuous physical effort)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
8.	For women only: <ul style="list-style-type: none"> Are you currently pregnant or breastfeeding? Have you ever been pregnant? If so, when was the last time? 	<input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no
Questions on infectious diseases that can be transmitted through blood			
9.	In the last 4 months, have you been working with extremely dangerous disease-causing agents (for example Ebola virus) or have you had otherwise contact with such an agent?	<input type="checkbox"/> yes	<input type="checkbox"/> no
10.	Have you ever been diagnosed <ul style="list-style-type: none"> With an inflammatory condition of the liver (hepatitis, "jaundice")? With a HIV (AIDS) or HTLV infection? 	<input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no
11.	<ul style="list-style-type: none"> In the last 4 months, have you had acupuncture? In the last 4 months, have you been tattooed or have you had another procedure causing injury to skin or mucous membranes such as body/ear piercing, permanent make-up, body modification? 	<input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no
12.	In the last 4 months, have you lived in the same household with a person who has been diagnosed with an inflammatory condition of the liver (hepatitis)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
13.	In the last 4 months, have you been exposed to the blood of another person, for example through the exposure of mucous membranes (including the eye) or through skin lesion with a sharp instrument (such as a needle stick injury)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
14.	Have you ever received a blood transfusion (red blood cells, platelets, plasma – including your own blood)? If so, when last?	<input type="checkbox"/> yes	<input type="checkbox"/> no
15.	In the last 4 months, have you had an endoscopy (of the stomach, the bladder or the bowel), a catheter treatment, a surgery or a tissue transplant?	<input type="checkbox"/> yes	<input type="checkbox"/> no
16.	Infections such as HIV or hepatitis can be transmitted through sex. Immediately after becoming infected with HIV and/ or hepatitis, blood donors who are still unaware of an infection can pass it on to the recipients of their blood. It can take up to 4 months, unfortunately, before laboratory tests are able to detect the presence of an infection reliably. Your honesty in answering this question protects the recipients of your donation.		
	In the last 4 months, have you had sexual intercourse <ul style="list-style-type: none"> With a total of more than two people, anal intercourse with a new person, or anal intercourse with more than one person? For which you received or paid money or other services (accommodation, drugs)? With a person infected with HIV or hepatitis viruses? With a person who was born abroad or lived there for more than 6 months? 	<input type="checkbox"/> yes	<input type="checkbox"/> no
	Have you taken medication to prevent HIV infection (PrEP) in the last 4 months?	<input type="checkbox"/> yes	<input type="checkbox"/> no
17.	Have you ever injected or snorted drugs?	<input type="checkbox"/> yes	<input type="checkbox"/> no

18.	Have you been in prison in the last 4 months?	<input type="checkbox"/> yes	<input type="checkbox"/> no
19.	Have you ever received injections with drugs that have not been prescribed by a doctor (for example muscle-enhancing substances or Botox)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
20.	<ul style="list-style-type: none"> Have you ever received living cells or tissue transplants from animals? In the last 12 months, have you been vaccinated against rabies after contact with an animal? In the last 12 months, have you received animal serum (e.g., for the treatment of snakebites)? 	<input type="checkbox"/> yes <input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no <input type="checkbox"/> no
21.	<ul style="list-style-type: none"> Have you been abroad, even briefly, within the last 6 months? If yes, where? Were you born abroad? If yes, where? Have you ever lived abroad for more than 6 months? If yes, where?..... When? 	<input type="checkbox"/> yes <input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no <input type="checkbox"/> no
22.	Have you ever been diagnosed with malaria?	<input type="checkbox"/> yes	<input type="checkbox"/> no
23.	Do you have or have you ever had tuberculosis, osteomyelitis, syphilis, rheumatic fever, enteric fever (typhoid or paratyphoid fevers caused by Salmonellosis), Q-fever, toxoplasmosis?	<input type="checkbox"/> yes	<input type="checkbox"/> no
24.	Were you ever diagnosed with any of the following rare diseases: Chagas disease (trypanosomiasis), brucellosis, babesiosis, leishmaniosis, leprosy, melioidosis, relapsing fever, tularaemia, typhus fever or other rickettsial diseases?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Questions on possible medication residues in blood			
25.	In the last 4 weeks or today on the donation day, have you taken tablets, or medication in other forms, such as antibiotics, painkillers (including aspirin, ASS), medicine against high blood pressure or other medication? If yes, which?	<input type="checkbox"/> yes	<input type="checkbox"/> no
26.	In the last 3 years, have you taken tablets to treat severe forms of eczema, psoriasis or acne (for example Tectino®, Neotigason®, Aknenormin®)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
27.	In the last 4 weeks, have you been vaccinated? If yes, against what?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Questions relating to transmissible brain diseases			
28.	Have you or one of your blood relatives been diagnosed with Creutzfeldt Jakob Disease or a similar disease, or has the presence of such a disease ever been suspected?	<input type="checkbox"/> yes	<input type="checkbox"/> no
29.	<ul style="list-style-type: none"> Were you treated with pituitary hormones before 1996, for instance because of growth disorders, endometriosis or desire to have children? Have you ever received a cornea transplant, a dura mater transplant, or any other transplants? 	<input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> no

Donor declaration

- I confirm that I have legal capacity and that the above name and address apply to me.
- I understood the above questions and answered them truthfully to the best of my knowledge and belief.
- I had the opportunity to ask questions and received satisfactory answers. I have no further questions at the moment.
- I agree to the blood donation and the necessary tests of my blood, including the HIV test by the blood donation service. Furthermore, I agree with the collection, use, processing, storage and transfer of my personal data, taking into account the requirements of the General Data Protection Regulation (DS-GVO), the Federal Data Protection Act (BDSG), the North Rhine-Westphalia Health Data Protection Act (GDStG NW), the Transfusion Act and the agree to the relevant data protection regulations in individual cases.
- I agree that the blood donation service exchanges necessary information about existing or previous illnesses with doctors and medical departments (e.g. health department), state and federal authorities and other blood donation services.
- I agree to have blood tests carried out at a later date (even after I have ceased to be an active donor) if this is necessary for safety reasons (e.g. infection of a patient; new pathogens).

- I am aware of the risks of blood donation and their possible consequences. I consciously accept this because I know how much my blood donation will benefit the recipients. I am aware that missing, incomplete or incorrect information may result in serious health risks for me or the recipients or even death for the recipients of my blood and that I am responsible and liable for any damage caused by intentional or negligent concealment. I declare that I have been made aware of these matters as part of the explanations given to me prior to my blood donation..
- If I have any doubts about my suitability to donate blood, I will immediately contact a doctor from the blood donation service and/or use the confidential self-exclusion.
- If I develop an illness (e.g. infection with fever or diarrhea) in the next 4 weeks or an infection with HIV, hepatitis, syphilis or another illness in the next 6 months, I will contact a doctor immediately to inform the blood donation service (Phone number: 0241-18996734 or 0241-8089328 ,available 24 hours a day, 7 days a week)

To be filled in by the doctor:

Aachen, _____

Physical examination: , _____

Suitable for donation : _

Yes ☐ No ☐

Blocked until: _____

Risks and side effects of whole blood donation and platelet donation

In individual cases, heart attacks and strokes have been observed in connection with blood donations in people with a corresponding predisposition_

The following complications are also possible:

Bruise/haematoma: ☐

Circulatory problems: ☐

Arterial puncture: ☐

Nerve puncture: ☐

Thrombophlebitis: ☐

Thrombosis: ☐

In addition to the general side effects, additional side effects can occur when donating platelets due to the use of citrate, see IN-TR-256.

I declare that all the statements I have made are to the best of my knowledge correct.

I have been informed of the above-mentioned risks of whole blood donation & platelet donation.

I have no further questions and would like to continue the donation process.

Donor's signature: _____

I have already received extensive information about the EU General Data Protection Regulation in accordance with Article 13 EU DSGVO when donating blood

Yes ☐

No ☐ If so:

☐ I would like to receive extensive information about this again

☐ I refrain from being informed about this again

Donors signature: _____

Signature of the doctor: _____

Notes on the medical consultation: _____