



Donation number

Opening hours

Donation center Basel

monday 10.30-19.00
tuesday 07.30-19.00
wednesday 07.30-16.00
thursday 07.30-16.00
friday 07.30-17.00
saturday 08.30-12.00

Hospital Liestal

wednesday 17.00-20.00

Not on/before holidays

Stiftung Blutspendezentrum SRK beider Basel, Hebelstrasse 10, CH-4031 Basel
Tel: +41(0) 61 265 20 90, Fax: +41(0) 61 265 20 49, blutspende-basel@usb.ch, www.blutspende-basel.ch

Donate Blood. Save Lives.

2017

Dear donor,
As of the following date you are kindly invited to donate blood.

Empty box for date of invitation

Please complete the questionnaire on the back of this page with a blue or black pen within 24 hours prior to your blood donation and bring it with you. If you have any questions, please contact us in order to check whether you are currently able to donate.

Table with 10 columns: Neu, Typ, RhD, Sysmex, Haemo, Blutdruck, Puls, Gewicht, FER, AKOE

Bemerkungen: (durch Personal auszufüllen)

Arzt-/Erstspendergespräch: [] Ja [] Nein
Spendetauglichkeit: [] Ja [] Nein
Falls «Nein», Grund:
Arzt:
Visum BSD:

Vollständigkeit des Fragebogens und Unterschrift überprüft
Datum:
Visum BSD:
Visum VP:
Identität kontrolliert: [] Ja [] Nein
Datum:
Visum BSD:
Entnahmedauer:

Medical Questionnaire

2017

You have just read the **information sheet for blood donors** and you think you may donate blood. We thank you for being willing to answer with the greatest sincerity the following questions. By doing so you will substantially contribute to your own safety and to the security of the patients who will receive your blood. Please confirm by signing overleaf that you have made yourself fully acquainted with the information sheet for blood donors and that you consent today to donate blood.

		Yes	No	Visa RBTS SRC
1.	Have you ever donated blood, in the past? If so, give date of last donation _____ Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Do you weigh more than 50 kg (respectively 110 lbs)?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Are you in good health at present?	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Have you been treated by a dentist or dental hygienist in the past 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	
5.	During the past 4 weeks have you been ill, received medical care, or had a temperature of more than 38° C (or 100° F)?	<input type="checkbox"/>	<input type="checkbox"/>	
6. a)	During the past 4 weeks, have you taken any medicines (tablets, injections, suppositories) – including without prescription? If so, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
b)	During the past 4 weeks, have you taken medicine for prostate enlargement or hair loss (e.g. Alopecia, Finacapil, Propecia or Proscar) or acne (e.g. Roaccutan, Curakne, Isotretinoin, Tretinac or Toctino)?	<input type="checkbox"/>	<input type="checkbox"/>	
c)	During the past 6 months, have you taken medicine to treat prostate enlargement (e.g. Avodart or Duodart)?	<input type="checkbox"/>	<input type="checkbox"/>	
d)	During the past 3 years, have you taken Neotigason® or Acicutan® (treatment of psoriasis)?	<input type="checkbox"/>	<input type="checkbox"/>	
7. a)	Have you ever received an immunotherapy (cells or serum of human or animal origin)?	<input type="checkbox"/>	<input type="checkbox"/>	
b)	During the past 12 months, have you been vaccinated to prevent rabies, hepatitis B or tetanus?	<input type="checkbox"/>	<input type="checkbox"/>	
c)	During the past 4 weeks, have you received any other vaccination? If so, please specify? _____ When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Have you ever had any of the health problems or disorders mentioned below?			
a)	Cardiac/circulatory or lung disease (e.g. high/low blood pressure, heart attack, breathing difficulty, stroke, loss of consciousness)?	<input type="checkbox"/>	<input type="checkbox"/>	
b)	Skin disease (e.g. wound, rash, eczema) or allergy (e.g. hay fever, asthma, medicines)?	<input type="checkbox"/>	<input type="checkbox"/>	
c)	Other diseases (diabetes, blood disease, coagulation disease, vascular disease, kidney disease, neurological disease, epilepsy, cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	
9.	During the past 12 months or since your last blood donation have you had <input type="checkbox"/> an illness? <input type="checkbox"/> an accident? <input type="checkbox"/> surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
10. a)	Have you ever received graft(s) of human or animal tissues?	<input type="checkbox"/>	<input type="checkbox"/>	
b)	Have you ever had a brain or a spinal cord surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
c)	Before 1.1.1986, were you ever treated with growth hormones?	<input type="checkbox"/>	<input type="checkbox"/>	
d)	Have you or has any member of your family had confirmed or suspected Creutzfeldt-Jakob disease?	<input type="checkbox"/>	<input type="checkbox"/>	
e)	Between 1.1.1980 and 31.12.1996, did you ever stay for a period of 6 months or more in the United Kingdom (UK) (England, Wales, Scotland, Northern Ireland, Isle of Man, Channel Islands, Gibraltar and the Falkland Islands)?	<input type="checkbox"/>	<input type="checkbox"/>	
f)	Have you received one or more blood transfusions since 1.1.1980?	<input type="checkbox"/>	<input type="checkbox"/>	

		Yes	No	Visa RBTS SRC
11.	During the past 6 months, did you travel outside Switzerland? a) If yes, where? _____ When did you return to Switzerland? _____ b) Did you have any clinical symptom (e.g. fever) during your stay abroad or since your return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
12. a)	Were you born outside Europe, did you grow up there or did you live there for 6 months or more? If yes, in which country? _____ If yes, since when have you lived in Europe? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b)	Was your mother born outside Europe or did she grow up there, or did she live there for more than 6 months? If yes, in which country? _____	<input type="checkbox"/>	<input type="checkbox"/>	
13. a)	Have you had any of the following diseases: <input type="checkbox"/> tuberculosis, <input type="checkbox"/> borreliosis, <input type="checkbox"/> brucellosis, <input type="checkbox"/> bone infection, <input type="checkbox"/> typhus, <input type="checkbox"/> Q fever, <input type="checkbox"/> toxoplasmosis, <input type="checkbox"/> babesiosis, <input type="checkbox"/> Chagas disease, <input type="checkbox"/> malaria, <input type="checkbox"/> leishmaniasis, <input type="checkbox"/> ebola, <input type="checkbox"/> zika? When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b)	Have you had a tick bite or been in contact with infectious diseases in the past 4 weeks? If yes, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
14.	During the past 4 months have you undergone: <input type="checkbox"/> tattooing, <input type="checkbox"/> a gastro-, colonoscopy, <input type="checkbox"/> acupuncture, <input type="checkbox"/> electric epilation, <input type="checkbox"/> permanent make-up, <input type="checkbox"/> body piercing, <input type="checkbox"/> contact with foreign blood (a stitch wound, blood splash hitting the eyes, the mouth or another part of the body)? If so, when? _____	<input type="checkbox"/>	<input type="checkbox"/>	
15.	Have you ever had jaundice (hepatitis) or a positive test for hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	
16.	Has anyone in your family circle, or your usual sexual partner, had jaundice (hepatitis) or a Zika infection during the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
17.	Have you been exposed to one of the following risk situations? <input type="checkbox"/> Change of sexual partner in the past 4 months <input type="checkbox"/> Sexual intercourse (with or without protection) with several partners in the last 12 months <input type="checkbox"/> During the past 12 months a stay of 6 months or longer in countries where AIDS is epidemic <input type="checkbox"/> Sexual intercourse between men since 1977 <input type="checkbox"/> Sexual intercourse for money, drugs or medication since 1977 <input type="checkbox"/> Drug injection at present or in the past <input type="checkbox"/> Positive test for the AIDS virus (HIV), syphilis or jaundice (hepatitis B and C)	<input type="checkbox"/>	<input type="checkbox"/>	
18.	During the past 12 months, have you had sexual intercourse with partners who <input type="checkbox"/> were exposed to any of the risk situations listed in question 17, or <input type="checkbox"/> received blood transfusions in countries where AIDS is epidemic, or <input type="checkbox"/> were treated for a blood-clotting disorder with medication produced from blood?	<input type="checkbox"/>	<input type="checkbox"/>	
For woman only				
19.	Have you ever been pregnant? If yes, state the date of your last pregnancy _____	<input type="checkbox"/>	<input type="checkbox"/>	
20.	Before 1.1.1986, did you receive hormone injections for infertility treatment?	<input type="checkbox"/>	<input type="checkbox"/>	

Consent form to be completed and signed by the donor:

- I hereby consent to donate my blood.
- I confirm by my signature that I have thoroughly read and understood all of the information sheet for blood donors and that any queries were satisfactorily answered.
- I confirm that my personal data are correct and that I have answered the questionnaire truthfully.
- I consent that the blood I donate undergoes testing, which may include genetic methods if necessary, and that a sample of my blood will be stored for possible subsequent tests according to the Federal law on therapeutic products. I agree to be informed about abnormal results.

- I am aware that a part of my donation can be used for the preparation of medicinal products.
- I furthermore consent that my donation or certain components thereof may be used for medical research after encoding or anonymization.
- Personal information given in connection with blood donation is subject to medical secrecy. It may only be used within Swiss Transfusion SRC (T-CH SRC) and the Regional Blood Transfusion Service SRC (RBTS SRC). The Regional Blood Transfusion Service is legally required to report notifiable diseases to the authorities.

Name: _____ First name: _____

Date: _____ Signature: _____ Date of birth: _____

Remarks:
(to be completed by RBTS/SRC)

Visa BTS



Information sheet for blood donors

Blood donation involves venipuncture on the inner side of the elbow and the withdrawal of about 500 ml of blood in about 10 minutes. This rapid blood loss is generally well tolerated by a person in good health. That is why it is important for you to be in good health. If the results of our examinations (arterial pressure and haemoglobin test) or your answers to the medical questionnaire show that donating your blood may involve an important risk for your health, we will not accept your blood donation. Nevertheless, in spite of all precautionary measures, certain undesirable events may not be completely avoided during or after blood donation:

- a transitory blood pressure drop,
- local complications at the puncture site (haematoma, blood vessel extension, lesion of the underlying nerve).

Most of these events are harmless and of short duration. Nevertheless exceptional or severe complications (e.g. a reduced mobility of the arm of longer persistence) cannot be totally excluded. Your blood donation centre will give you useful advice on the best way to avoid or to treat them. In case of hazardous occupations or hobbies a minimal interval of 12 hours must be respected.

Precautionary measures to reduce the risk of your blood donation for the recipient:

1. Risk situations

There is a risk whenever infectious agents in your blood are transmitted to a patient even if you are not sick or do not feel sick. Your answers to the medical questionnaire help us to evaluate this risk. The T-CH SRC has established clear guidance to determine your ability to donate blood. Consequently you may be excluded from blood donation, either for a transitory period or in a permanent way.

The following risk situations represent a permanent contraindication for blood donation

1. Positive test for the biological markers of AIDS (HIV), syphilis, hepatitis C and persisting/active hepatitis B
2. Male sexual intercourse* with one or several men since 1977
3. Sexual intercourse* for money, drugs or medication since 1977
4. Drug injection (at present or in the past)
5. Blood transfusion after 01.01.1980

The following risk situations represent a temporary contraindication for blood donation

6. Stay during the past 6 months in a region where malaria is endemic, without any health problem (in case of illness with fever, tell the doctor in charge)
7. Gonorrhoea or other sexually transmitted disease during the past 12 months
8. Change of sexual partner* during the past 4 months
9. Sexual intercourse* with multiple partners during the 12 past months
10. Stay of 6 months or longer in the past 12 months in countries with a high AIDS rate
11. Sexual intercourse* during the 12 past months with partners exposed to one of the risk situations mentioned under 1 to 5 or 7 to 10, however deferral after sexual contact with partners with hepatitis B or C is 6 months.

*whether protected or not

At any time before, during or after donating, you may withdraw from blood donation and prohibit the use of your donated blood if it has not yet been transfused.

2. Laboratory tests

Every blood donation is tested for HIV (AIDS), hepatitis B and C viruses (jaundice), the syphilis agent and, if necessary, Parvo B19 and hepatitis A virus. Should any of the test results indicate any disease, you will immediately be informed and the blood you donated will not be used. However, there may be a time lapse between becoming infected and the laboratory tests showing a positive result. Therefore, if you donate blood during this time lapse, an infectious disease may be transmitted from you to the recipient without the transfusion centre being able to detect or prevent it. This is why it is of the utmost importance that you answer the questionnaire truthfully. The ABO, Rhesus D blood group and possibly other characteristics that may be relevant to transfusion medicine are determined for each donor (if necessary by genetic methods).

3. Please inform your blood donation centre as soon as possible, if::

- you or one of your close contacts fall sick in the course of the next days,
- you realize that you did not answer correctly one of the questions of the medical questionnaire,
- your blood donation is followed by complications. Proved harm may be covered by a civil liability insurance.

Personal information given in connection with blood donation is subject to medical secrecy. It will only be used within Swiss Transfusion SRC and the Regional Blood Transfusion Service. The Regional Blood Transfusion Service is legally required to report notifiable diseases to the authorities.