

BA  
11

Feld für Ersatz-  
Konservnummer

Mit  
Konservnummer  
überkleben

Ersatzpass  Wiederholungsspender  Adressänderung  Anzahl Spenden

männlich  weiblich  Namensänderung  Spenderehrung

Please fill out the form in capital letters only if you are a first time donor (no copy of donor-ID above) or in case of change of name and/or address

Date of birth	T	T	M	M	J	J	J	J	Telephone number (opt.)									
Surn./Last name																		
Given/First name																		
Maiden/nee																		
Street/APO-N°																		
District, Unit/Barracks																		



**ABO** **RH-D** **POS/NEG**

**Kontrolle Lichtbildausweis:**  
**66**  OK  nicht OK  
 Signum

Ärztlicher Befund

**60** RR   /   **61** Puls/Min    **62** Temperatur

**63** Arminsp.  **64** Gew.    kg **65** Datum letzte Blutspende

Zeit/Dauer   Monate Sperrgrund   Schlüssel  Spendefähig? ja  Spendefähig? nein

Begründung der Sperre/Bemerkungen

Unterschrift Arzt

**Besondere Vorkommnisse**  
 Hämatom  Nachblutung  Kollaps  RR   /   Puls/Min

Unterschrift Arzt

FNA  keine Punktion  KonsNr. nicht verwendbar  Venüle  unsteril   
 Signum

<input type="text"/> <input type="text"/> <input type="text"/> Hämoglobin	<input type="text"/>	<input type="text"/>	1. Punktion	<input type="text"/>	Datum Entnahmeort
<input type="checkbox"/> nicht ausreichend	Signum Etikett	Signum Nummernvergleich/Pers.-ID	2. Punktion	Signum Abnahme	
Signum Labor			Signum Punktion		

V.Nr. 1.17 Art. 06673 12/2019 SOP: HVE 023-G

012345

Name and address of your physician:

	Yes	No	
Do you feel sick or are you on sick leave?	<input type="checkbox"/>	<input type="checkbox"/>	01
Within the last 4 weeks: Do/Did you have an illness accompanied by fever? Do/Did you have contact with anyone with an infectious disease such as mumps, chicken pox, etc?	<input type="checkbox"/>	<input type="checkbox"/>	02
Do you take any medication (including vitamins containing Biotin)? If yes, which?	<input type="checkbox"/>	<input type="checkbox"/>	04
Did you ever take one of the following medications: Roaccutan®, Accutane®, Trivane®, Liderma®, Lurantal®, Tigason®, Tegison® or Neo-Tigason®? Have you ever received a corneal or meningeal transplant or tissue transplants and live cells of animal origin?	<input type="checkbox"/>	<input type="checkbox"/>	05
Have you ever been treated with hormones of the pituitary gland of human origin?	<input type="checkbox"/>	<input type="checkbox"/>	06
Have you been outside of Germany within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	07
<b>To be filled out by the physician:</b> West-Nile-Virus-Exposure within the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been vaccinated within the last 3 months or have you received serum/immunoglobulins of animal origin within the last 12 months (e.g. against rabies after contact with an animal)?	<input type="checkbox"/>	<input type="checkbox"/>	08
Within the last 7 days: Did you have an uncomplicated infection (e.g. catarrh, cold, urinary tract infection) without fever?	<input type="checkbox"/>	<input type="checkbox"/>	01
Have you received blood or blood derivatives within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	09
Have you had an injury/accident, surgery, an endoscopy or contact with blood (e.g. pinprick, contact with mucous membrane) within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a contagious inflammatory liver disease (infectious hepatitis) e.g. hepatitis A, B, C?	<input type="checkbox"/>	<input type="checkbox"/>	10
Within the last 4 months: have you been in close contact (e.g. symbiotic community) with a risk of an infection with hepatitis virus (HBV, HCV, HAV)?	<input type="checkbox"/>	<input type="checkbox"/>	11
Do/Did you have active tuberculosis, toxoplasmosis, osteomyelitis, syphilis, gonorrhoea or Queensland fever?	<input type="checkbox"/>	<input type="checkbox"/>	12
Do/Did you have gastro-intestinal diseases? Do/Did you have diarrhea within the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	43
Have you ever had: Babesiosis, Trypanosomiasis (Chagas disease), Leishmaniasis, Brucellosis (malta fever), spotted fever or other forms of Rickettsioses, leprosy, relapsing fever, Melioidosis or Tularemia (rabbit fever)?	<input type="checkbox"/>	<input type="checkbox"/>	13
Do/Did you ever have malaria? Did you stay outside Europe for longer than 6 months without interruption? Were you born or did you grow up there?	<input type="checkbox"/>	<input type="checkbox"/>	14
Are you a typhoid, paratyphoid or salmonella carrier?	<input type="checkbox"/>	<input type="checkbox"/>	15
Have you been tattooed, acupuncture or body pierced or did you have an ear piercing within the past 4 months?	<input type="checkbox"/>	<input type="checkbox"/>	16
Did you have a dental treatment or professional tooth cleaning within the last 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	17
Do/Did you have a blood disorder, tumor (e.g. cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	18
Do/Did you ever have diseases of the central nervous system (e.g. epilepsy, stroke), psychological diseases, repeated faints?	<input type="checkbox"/>	<input type="checkbox"/>	19
Do/Did you have a liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	20
Have you or has a family member been affected by Creutzfeld-Jacob disease (CJD), or a variant of CJD?	<input type="checkbox"/>	<input type="checkbox"/>	22

	Yes	No	
phlebitis, vascular diseases, thrombosis, embolism or bleeding tendency?	<input type="checkbox"/>	<input type="checkbox"/>	21
diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	25
a chronic kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	26
cardiac discomfort, heart attack, shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	33
lung disease, asthma, unexplained cough?	<input type="checkbox"/>	<input type="checkbox"/>	34
allergic discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	35
rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	36
extensive skin disease?	<input type="checkbox"/>	<input type="checkbox"/>	37
herpes infection within the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	38
enlarged lymphnodes?	<input type="checkbox"/>	<input type="checkbox"/>	39
Do you stay in the United Kingdom or Northern Ireland for more than 6 months overall in the period from January 01 <sup>st</sup> , 1980 to December 31 <sup>st</sup> , 1996?	<input type="checkbox"/>	<input type="checkbox"/>	
Did you undergo surgery in the United Kingdom or Northern Ireland after January 01 <sup>st</sup> , 1980?	<input type="checkbox"/>	<input type="checkbox"/>	67
Have you ever received a blood transfusion in the United Kingdom or Northern Ireland?	<input type="checkbox"/>	<input type="checkbox"/>	
Do/ Did you have issues with drugs or do you have other addictions?	<input type="checkbox"/>	<input type="checkbox"/>	29
Do/ Did you belong to one of the following group of people: - Heterosexual intercourse with more than 3 sexual partners within the last 12 months? - Men who have sexual intercourse with men (MSM)? - People who offer sexual intercourse for money or for other services, e.g. drugs, ("male and female sex workers") - Transsexual persons with sexual risk behaviour?	<input type="checkbox"/>	<input type="checkbox"/>	54
	<input type="checkbox"/>	<input type="checkbox"/>	55
Do/ Did you belong during the last 4 months to one of the following high-risk groups: - Sexual contact with persons corresponding to question 54/55? - Entry from countries with increased infection rates of hepatitis B or C, HTLV-1/2 or HIV, where you stayed continuously longer than 6 months? - Sexual contact with a person who lives or entered from countries with increases infection rates of HBV, HCV, HIV? - Have you been in prison within the last 4 months?	<input type="checkbox"/>	<input type="checkbox"/>	56
Did you ever have a verified infection with HIV-1 or HIV-2 (AIDS) or HTLV-1 or HTLV-2?	<input type="checkbox"/>	<input type="checkbox"/>	32
<b>females only:</b> Have you ever been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been pregnant in the last 24 months or are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	23

**Signatur of blood-donor:**

**Fill out when you see the physician:**

**First time donor:** I received medical information about donor risks.

**Multiple donor:** My questions about the sheet "Information about whole blood donation and your willingness to donate blood" have been answered.

**Vom Arzt auszufüllen:** Sollte der Spender eine oder mehrere Fragen mit „Ja“ beantwortet haben und trotzdem spenden können, so muss jedes „Ja“ hier mit einer Kurzbegründung berichtigt werden, ggf. die Untersuchung erweitert werden, z.B. Mundinspektion etc.

**TK verwendbar:**  **Nicht für Pädiatrie:**

Anyone who donates blood by deliberately giving false informations, e.g. withholding information regarding themselves belonging to a high risk group (see question 54/55) that places a third party at a risk for contracting AIDS-causing virus or Hepatitis B or Hepatitis C can be prosecuted by law.

I have answered all questions truthfully and have received, read and understood the "information about whole blood donation and your willingness to donate whole blood" about the clarification and consent of blood donors and possible risks. Furthermore, the doctor informed me about the purpose and use of my personal data. I had the opportunity to ask questions in the course of the conversation with the doctor.

I give my signed consent to a blood donation and to have my blood tested, including such testing which serves the promotion of scientific realizations in the area of health service and a blood donation used for transfusion. Any abnormal lab results will be passed on to my named doctor. The information regarding your family doctor is voluntary. In the event of an abnormal finding, it enables the prompt transmission of the findings to your physician. If you do not want to specify the family doctor, leave the field blank or delete the name you have already given.

I waive the issuance of the Information and Consent Form.

