BA 11

Feld für Ersatz-Konservennummer

Mit Konservennummer 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	
	Zip — City

* B A 1 1 V 0 1 *

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 ☐☐☐☐☐☐ Spendefähig? ja ☐

Zeit/Dauer ☐☐ Monate Sperrgrund ☐☐ Schlüssel 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

☐☐☐ Hämoglobin

☐ nicht ausreichend

Signum Labor | Signum Etikett | Signum Nummern-vergleich/Pers.-ID | 1. Punktion 2. Punktion Signum Punktion | Signum Abnahme | Datum Entnahmeort

012345

V.Nr.1.19 Art. 06673 07/2020 SOP: HVE 023-G

To fill out by the donor! Please mark correct answer with a cross. **Your weight in kg:** | | | **Height in cm:** | | | 012345

Name and address of your physician:

	Yes	No	
Do you feel sick or are you on sick leave?	☐	☐	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?	☐	☐	02
Do you take any medication (including vitamins containing Biotin)? If yes, which?	☐	☐	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?	☐	☐	05
Have you ever been treated with hormones of the pituitary gland of human origin?	☐	☐	06
Have you been outside of Germany within the last 6 months? Have you been outside of Bavaria two days in a row within the last 4 weeks?	☐	☐	07
To be filled out by the physician: West-Nile-Virus-Exposure within the last 4 weeks?	☐	☐	
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)?	☐	☐	08
Within the last 7 days: Did you have an uncomplicated infection (e.g. catarrh, cold, urinary tract infection) without fever?	☐	☐	01
Have you received blood or blood derivatives within the last 24 months?	☐	☐	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?	☐	☐	09
Have you ever had a contagious inflammatory liver disease (infectious hepatitis) e.g. hepatitis A, B, C?	☐	☐	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)?	☐	☐	11
Do/Did you have active tuberculosis, toxoplasmosis, osteomyelitis, syphilis, gonorrhoea or Queensland fever?	☐	☐	12
Do/Did you have gastro-intestinal diseases? Do/Did you have diarrhea within the last 4 weeks?	☐	☐	43
Have you ever had: Babesiosis, Trypanosomiasis (Chagas disease), Leishmaniosis, Brucellosis (malta fever), spotted fever or other forms of Rickettsioses, leprosy, relapsing fever, Melioidosis or Tularemia (rabbit fever)?	☐	☐	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?	☐	☐	14
Are you a typhoid, paratyphoid or salmonella carrier?	☐	☐	15
Have you been tattooed, acupunctured or body pierced or did you have an ear piercing within the past 4 months?	☐	☐	16
Did you have a dental treatment or professional tooth cleaning within the last 7 days?	☐	☐	17
Do/Did you have a blood disorder, tumor (e.g. cancer)?	☐	☐	18
Do/Did you ever have diseases of the central nervous system (e.g. epilepsy, stroke), psychological diseases, repeated faints?	☐	☐	19
Do/Did you have a liver disease?	☐	☐	20
Have you or has a family member been affected by Creutzfeld-Jacob disease (CJD), or a variant of CJD?	☐	☐	22

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.

Blutspendedienst des Bayerischen Roten Kreuzes
Herzog-Heinrich-Str. 2
80336 München

		Yes	No	
Do/Did you have:	phlebitis, vascular diseases, thrombosis, embolism or bleeding tendency?	☐	☐	21
	diabetes?	☐	☐	25
	a chronic kidney disease?	☐	☐	26
	cardiac discomfort/disease/infarction, shortness of breath?	☐	☐	33
	lung disease, asthma, unexplained cough?	☐	☐	34
	allergic discomfort?	☐	☐	35
	rheumatic fever?	☐	☐	36
	extensive skin disease?	☐	☐	37
	herpes infection within the last 4 weeks?	☐	☐	38
	enlarged lymphnodes?	☐	☐	39
Did you stay in the United Kingdom or Northern Ireland for more than 6 months overall in the period from January 01st, 1980 to December 31st,1996?		☐	☐	67
Did you undergo surgery in the United Kingdom or Northern Ireland after January 01st, 1980? Have you ever received a blood transfusion in the United Kingdom or Northern Ireland?		☐	☐	67
Do/did you consume drugs or other addictive substances?		☐	☐	29
Did you have sexual intercourse with more than 3 sexual partners within the last 12 months? If yes: When the last time? _____		☐	☐	54
Did you ever have sexual intercourse for getting money or other services, e.g. drugs, accommodations? When yes: When the last time? _____	within the last 12 months	☐	☐	54 (< 12 months)
As a man: Did you ever have sexual intercourse with another man? If yes: When the last time? _____	more than 12 months ago	☐	☐	55 (> 12 months)
Did you have sexual intercourse within the last 4 months -with a person, who is infected with HIV- or hepatits-virus? -with a person who is born outside Europe? -for offering money or other services, e.g. drugs, accommodations? - as **a woman** with a bisexual man?		☐	☐	56
- Have you been in prison within the last 4 months?				56
Did you ever have a verified infection with HIV-1 or HIV-2 (AIDS) or HTLV-1 or HTLV-2?		☐	☐	32
Only for women: Have you ever been pregnant?		☐	☐	23
Have you been pregnant in the last 24 months or are you breastfeeding?		☐	☐	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:** ☐

Anamnese überprüft Unterschrift Arzt