

BA
11

Feld für Ersatz-
Konservnummer

Mit
Konservnummer
überkleben

Ersatzpass männlich
 Wiederholungsspender weiblich
 Adressänderung
 Namensänderung
 Anzahl Spenden
 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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone number (opt.)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surn./Last name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Given/First name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Maiden/nee	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street/APO-N°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
District, Unit/Barracks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Zip	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



ABO RH-D POS/NEG

Kontrolle Lichtbildausweis:

66 OK nicht OK

Signum

Ärztlicher Befund

<input type="text"/>	60 RR	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	61 Puls/Min	<input type="text"/>	<input type="text"/>	<input type="text"/>	62 Temperatur	<input type="text"/>	<input type="text"/>	<input type="text"/>	63 Arminsp.	<input type="checkbox"/>
<input type="text"/>	64 Gew.	<input type="text"/>	<input type="text"/>	kg	65 Datum letzte Blutspende	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Spendefähig? ja	<input type="checkbox"/>
<input type="text"/>	Zeit/Dauer	<input type="text"/>	<input type="text"/>	Monate	Sperrgrund	<input type="text"/>	<input type="text"/>	Schlüssel	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Spendefähig? nein	<input type="checkbox"/>

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

V.Nr: 121 Art: 06673 01/2022 SOP: HVE 023-G

012345

Name and address of your physician:

Please mark correct answer with a cross:

	Yes	No	
Do you feel sick or are you on sick leave today (day of donation)? 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
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 measles, mumps, chicken pox, COVID-19/"corona"?	<input type="checkbox"/>	<input type="checkbox"/>	02
Within the last 4 weeks or today (day of donation): Do/Did you use any medication (including aspirin/ASS, medicaments against high blood pressure or else)? Vitamins, especially containing biotin?	<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/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 6 months? Where and when?	<input type="checkbox"/>	<input type="checkbox"/>	07
Have you been vaccinated within the last 4 weeks? Did you receive within the last 12 months serum/immunoglobulins of animal origin (e.g. against rabies after contact with an animal)?	<input type="checkbox"/>	<input type="checkbox"/>	08
Do you give blood also in other blood donation services?	<input type="checkbox"/>	<input type="checkbox"/>	65
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
Do/did you have: Babesiosis, Trypanosomiasis (Chagas disease), Leishmaniosis, 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
Were you born or did you grow up outside Europe? Did you stay there for longer than 6 months without interruption? Do/Did you have malaria?	<input type="checkbox"/>	<input type="checkbox"/>	14
Are you a typhoid, paratyphoid or other 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 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

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.

	Yes	No		
Do/Did you have:	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/disease/infarction, 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
	enlarged lymphnodes?	<input type="checkbox"/>	<input type="checkbox"/>	39
	Have you been taken a medical HIV preexposure prophylaxis (PrEP) within the last 4 months?	<input type="checkbox"/>	<input type="checkbox"/>	56
Did you stay in the United Kingdom or Northern Ireland for more than 6 months overall in the period from January 01 st , 1980 to December 31 st , 1996?	<input type="checkbox"/>	<input type="checkbox"/>	67	
Did you undergo surgery in the United Kingdom or Northern Ireland after January 01 st , 1980? Have you ever received a blood transfusion in the United Kingdom or Northern Ireland?	<input type="checkbox"/>	<input type="checkbox"/>		
Did you ever have injected or snuffed drugs or not medically prescribed substances? Are you alcoholic?	<input type="checkbox"/>	<input type="checkbox"/>	29	
Did you have sexual intercourse with more than 2 partners within the last 4 months? If yes: When the last time? _____	<input type="checkbox"/>	<input type="checkbox"/>	54	
Did you ever have sexual intercourse for getting money or other services, e.g. drugs accommodations? If yes: When the last time? _____	<input type="checkbox"/>	<input type="checkbox"/>	54	
As a man: Did you ever have sexual intercourse with another man? If yes: When the last time? _____	<input type="checkbox"/>	<input type="checkbox"/>	54	
As a woman please answer with "no" Did you have sexual intercourse within the last 4 months with a person, who is born outside Europe? Did you have sexual intercourse within the last 4 months -with a person who is infected with HIV- or hepatitis virus? -for offering money or other services, e.g. drugs, accommodations? -as a woman with a bisexual man?	<input type="checkbox"/>	<input type="checkbox"/>	56	
Have you been in prison within the last 4 months?	<input type="checkbox"/>	<input type="checkbox"/>		
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	
Only for women: Have you ever been pregnant? Have you been pregnant in the last 24 months or are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	23	
	<input type="checkbox"/>	<input type="checkbox"/>		

Signatur of blood-donor:

Fill out when you see the physician:

First time donor: I received medical information about donor risks.	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple donor: My questions about the sheet "Information about whole blood donation and your willingness to donate blood" have been answered.	<input type="checkbox"/>	<input type="checkbox"/>	

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 berichtet werden, ggf. die Untersuchung erweitert werden, z.B. Mundinspektion etc.

TK verwendbar:

Nicht für Pädiatrie:

