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| -UC Irvine Blood Donor Center  Donor Screening Record |

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| --Affix Donor Label Here-- | | Donor  Initials: | |
| Mobile  ID#: | **□ NA** |
| **Permanent**  **EDD ID#:** | |
| DIN: | 2nd VP  DIN: | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Today’s Date:** MM / DD / YYYY | | | | | |
| **LEGAL LAST** **Name** | | | | | | **LEGAL FIRST** **Name** | M.I./**M.I./Middle Name** | | Suffix | | **Nickname** | | |
|  | | | | | |  | | |  | |  | | |
| ***Current Address (Number and Street) Apt /Unit #*** | | | | |  | ***What other name(s) have you EVER donated or***  ***attempted to donate under?***  **□ NA** | | | EVER ***donate*** or ***try*** to donate?  □Yes □No  If yes, when? | | | | |
|  | | | | | |
| **City** | | | **State** | **Zip Code** | | **Date of Birth**  M M / D D / Y Y Y Y | | **Age** | **Allergic to:** | | | | |
| **□Latex** | **□Iodine** | | □Neither | |
| Phone #  **( )** | **-** | **□ Cell**  **□ Home**  **□ Business** | | | | **Gender □Male □Female □Nonbinary** | | | Email address | | | |  |

**------------------------------------------------*STAFF USE ONLY BELOW THIS POINT*------------------------------------------------**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A. **Collection Type:** | | | | | | | WB | | | | | | Apheresis | | | | | | Sample | | | | **Donor Consent** | | | | | | | | | | | | | | | |
| **Intended Use:** | | | | | | | Allo(L) | | | | | | Designated(S) | | | | | | Directed(D) | | | | \*I have reviewed and understand the Blood Donor Information and Blood Donor Educational Materials  \*I have had all my questions answered to my satisfaction  \*I will not donate if I believe that my blood is not suitable for transfusion  \*I understand that I can withdraw from the blood donation process at anytime  \*I understand a sample of my blood may be used for research | | | | | | | | | \*I understand there are risks associated with donating blood which include but not limited to: bruising, nerve injury, loss of red blood cells, weakness, nausea, fainting, chills, muscle twitching, and tenderness at needle site.  \*I certify that I have answered all questions truthfully and to the best of my knowledge  \*I consent to the blood donation process | | | | | | |
| ID Type:  EID  Pass | CDL/CID  SID  Other | | | | | UCI/UCLA EID  OOSDL\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | Q. Other  Name(s) ✓’d by: | | | | | | NA | |
| B. Photo ID ✓’d by: | | | | | | | |
| ID #: | | | | | | | | | | | No ID #  Available | | | | C. Eligibility ✓’d by: | | | | | | | |
| **VP #1** | | | **DSR Reviewed?**  **Yes** | | | | | | | |  | | | | See ACHR for APH Procedure | | | | | | | |
| O. VP#1 By: | | | | | | | | | Arm: L R | | | | | | | | Iodine ChloraP | | | | | | **Donor Signature:** | | | | | | | | | | | | | **Date:** | | |
| Start 1st VP: | | | |  | | | | | | L. Bag Type: PAS3DIL | | | | | | | | | | | | | **Health Historian Signature:** | | | | | | | | | | | | | | | |
| Stop 1st VP: | | | |  | | | | | | K. Bag Lot #: | | | | | | | | | | | | | I. Wt | | | F. Temp  Therm ID #: | | | G. Pulse | H. BP | | | | N. Arms  S  U | | | | E. Hgb  HCue ID # |
| # Minutes: | | | |  | | | | | | M. Scale ID #: | | | | | | | | | | | | |
| Volume: | | | | mL | | | | | | P. **Failure Code** | | | | | | | | | | | | |
| **VP #2** | | | **DSR Reviewed? Yes** | | | | | | 2nd VP Consent? Yes No | | | | | | | | | | | | | | **OK to donate?** **Yes Deferred** | | | | | | | | I have been notified of the reason(s) and length of deferral, type of future donations, availability of medical counseling, and that my name will be placed in UC’s internal deferral database.  **Donor Initials:** | | | | | | | |
| O. VP#2 By: | | | | | | | | | Arm: L R | | | | | | | | Iodine ChloraP | | | | | | **D. Deferral Code(s)** | | | | | **NED** | | |
| Start 2nd VP: | | | | | | | | | L. Bag Type: PAS3DIL | | | | | | | | | | | | | |
| Stop 2nd VP: | | | | | | | | | K. Bag Lot # | | | | | | | | | | | | | |
| # Minutes: | | | |  | | | | | M. Scale ID # | | | | | | | | | | | | | |  | **Comments (Staff Use Only)** | | | | | | | | | | | | | | |
| Volume: | | | | mL | | | | | P. **Failure Code** | | | | | | | | | | | | | |
| **J. Reaction:** Mild Moderate\* Severe\* \*Refer to Donor Reaction Report Form | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |
| Dnr Profile/Visit  \_\_\_\_/\_\_\_\_initials | | | | | Physical Exam  NA \_\_\_\_\_initials | | | | | | | | | Draw Detail  NA \_\_\_\_\_initials | | | | Deferral(s)  NA \_\_\_\_\_initials | | | | Failure Code  NA \_\_\_\_\_\_\_\_initials | | | | | Special Inst | | | | | | TRALI | | | | Reaction  NA \_\_\_\_\_initials | |
| NA \_\_\_\_\_\_\_initials | | | | | | LATEXIODINE | | | |
| **Alert** | | Q | | | | | | X | | | | AB | | | | S CP | | | | **Ent on BCL By:**  **\_**\_\_initials NA | | | | | **EDD Record Review OK?** Yes No NA  **EDD Record Review By:** \_\_\_\_\_initials | | | | | | | | | | **DSR Final Rev By:**  initials | | | |
| **Code(s):** | | CMV | | | | | | TR | | | | HLA | | | |  | | | |

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| **PLEASE ANSWER ALL QUESTIONS & APPLICABLE GENDER QUESTIONS BY CHECKING ‘YES’ OR ‘NO’** | | |
| **ARE YOU:** | **Yes** | **No** |
| 1. Feeling healthy and well today? |  |  |
| 1. Currently taking an antibiotic? |  |  |
| 1. Currently taking any other medication for an infection? |  |  |
| **PLEASE READ THE EDUCATIONAL MATERIALS, INCLUDING THE MEDICATION DEFERRAL LIST** | **Yes** | **No** |
| 1. Have you taken any medications on the Medication Deferral List in the time frames indicated? **(Review the Medication Deferral List)** |  |  |
| 1. Have you read the educational materials today? |  |  |
| **IN THE PAST 48 HOURS:** | **Yes** | **No** |
| 1. In the **PAST 48 hours** have you taken aspirin or anything that has aspirin in it? |  |  |
| **IN THE PAST 8 WEEKS HAVE YOU:** | **Yes** | **No** |
| 1. Donated blood, platelets or plasma? |  |  |
| 1. Had any vaccinations or other shots? |  |  |
| 1. Had contact with someone who was vaccinated for smallpox in the past 8 weeks? |  |  |
| **IN THE PAST 3 MONTHS HAVE YOU:** | **Yes** | **No** |
| 1. Had a blood transfusion? |  |  |
| 1. Had a transplant such as organ, tissue, or bone marrow? |  |  |
| 1. Had a graft such as bone or skin? |  |  |
| 1. Come into contact with someone else's blood? |  |  |
| 1. Had an accidental needle-stick? |  |  |
| 1. Had sexual contact with anyone who has ever had HIV/AIDS or has ever had a positive test for the HIV/AIDS virus? |  |  |
| 1. Had sexual contact with a prostitute or anyone else who has ever taken money or drugs or other payment for sex? |  |  |
| 1. Had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything not prescribed by their doctor? |  |  |
| 1. **Male donors:** Had sexual contact with another male? |  |  |
| 1. **Female Donors:** Had sexual contact with a male who had sexual contact with another male in the past 3 months? |  |  |
| 1. Had a tattoo? |  |  |
| 1. Had ear or body piercing? |  |  |
| 1. Had or been treated for syphilis or gonorrhea? |  |  |
| 1. Used needles to take drugs, steroids, or anything not prescribed by your doctor? |  |  |
| 1. Received money, drugs, or other payment for sex? |  |  |
| **IN THE PAST 16 WEEKS:** | **Yes** | **No** |
| 1. Have you donated a double unit of red cells using an apheresis machine? |  |  |
| **IN THE PAST 12 MONTHS, HAVE YOU** | **Yes** | **No** |
| 1. Had sexual contact with a person who has hepatitis? |  |  |
| 1. Lived with a person who has hepatitis? |  |  |
| 1. Been in juvenile detention, lockup, jail, or prison for 72 hours or more consecutively? |  |  |
| **IN THE PAST THREE YEARS, HAVE YOU** | **Yes** | **No** |
| 1. Been outside the United States or Canada? |  |  |
| **FROM 1980 THROUGH 1996:** | **Yes** | **No** |
| 1. Did you spend time that adds up to three (3) months or more in the United Kingdom countries of England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands? |  |  |
| **FROM 1980 THROUGH 2001, DID YOU** | **Yes** | **No** |
| 1. Spend time that adds up to 5 years or more in France or Ireland? Time spent in Ireland does not include time spent in Northern Ireland which is part of the United Kingdom. |  |  |
| **FROM 1980 TO THE PRESENT, DID YOU:** | **Yes** | **No** |
| 1. Receive a blood transfusion in France, Ireland, England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands? |  |  |
| **HAVE YOU EVER:** | **Yes** | **No** |
| 1. **Female Donors:** Have you **EVER** been pregnant or are you pregnant now? |  |  |
| 1. Had a positive test for the HIV/AIDS virus? |  |  |
| 1. Had malaria? |  |  |
| 1. Received a dura mater (or brain covering) graft or xenotransplantation product? |  |  |
| 1. Had any type of cancer, including leukemia? |  |  |
| 1. Had any problems with your heart or lungs? |  |  |
| 1. Had a bleeding condition or a blood disease? |  |  |
| 1. Had a positive test result for Babesia? |  |  |
| **ADDITIONAL QUESTIONS:** | **Yes** | **No** |
| 1. In the past **3 months,** have you taken any medication to prevent an HIV infection? |  |  |
| 1. Have you **EVER** taken any medication to treat an HIV infection? |  |  |
| 1. Within the last year have you been under a Doctors care, had a major illness or had surgery? |  |  |
| 1. Have you **EVER** been deferred or refused as a blood donor or told not to donate for any reason? |  |  |
| **Comments (Staff Use Only)** | | |
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