

Registration Officer's Signature

Weight	Hgb Barcode <i>Test 1</i>	Hgb Result 1	CBC Barcode <i>Test 1</i>	CBC Result 1	Weight (Bag)	Machine
Height	Hgb Barcode <i>Test 2</i>	Hgb Result 2	CBC Barcode <i>Test 2</i>	CBC Result 2	Nurse's Signature	
Temperature	Hgb Barcode <i>Test 3</i>	Hgb Result 3	Pre-Donation Officer's Signature			

Donor Declaration:

- Today, I declare that I have understood and completed this questionnaire. All the information I provided is true and accurate to the best of my knowledge. I consent to the NBTS evaluating any details about me which might preclude me from donating blood. Should I be found to have consciously given incorrect information which could affect my donation eligibility, I understand that NBTS may take **legal** proceedings against me.
- I entrust my blood donation to the NBTS to be used for the benefit of patients, which may include **research**.
- I give permission that the necessary **tests** are performed, including that of HIV, on the blood that I am going to donate. I have been informed that a small sample of blood will be stored. To the best of my knowledge I am not at risk of any infections nor of transmitting any infectious diseases, and I am aware that NBTS may **notify** Public Health of any communicable infection identified.
- I agree that I have been given **enough information** on the procedure and risks of blood donation and I had an opportunity to ask questions and had satisfactory responses to any questions I asked. I also consent that all necessary medical attention be given to me should the need arise.
- I have been given instructions on post donation activities and behaviour; these instructions have been clearly explained to me and if I refrain from heeding them, I will do so at my own risk.
- I also accept that my name could be included in the **confidential file** of deferrals.
- If I develop **any illness** within 1 week of blood donation, I will **immediately** phone one of the Medical Staff at NBTS, as this illness may have consequences for the patients who will receive my blood.

Will you accept text messages from NBTS?

Yes No

Will you accept emails from NBTS?

Yes No

**450ml
Special
Request**

Circle where applicable

Eligible

Not Eligible

DONOR'S SIGNATURE _____

MEDICAL DOCTOR'S SIGNATURE _____

Please read this questionnaire carefully. It is to be filled in with the attending healthcare professional during the medical interview.

Your **COMPLETE HONESTY** in answering all the questions is essential for your safety and for the safety of the patients who will receive your blood. Your donation will be tested for the blood group and infectious diseases (including HIV, Hepatitis B, Hepatitis C, Hepatitis E, CMV, West Nile Virus and Syphilis). Please note that even though rigorous testing is performed on donations, there is always a slight chance of infections not being detected with the current technology. Never donate blood to get tested; if you do, you risk infecting other people.

WHY DO YOU WANT TO GIVE BLOOD? (To be discussed with the healthcare professional)

PERSONAL HISTORY	YES	NO
1 Are you well and healthy at present?	<input type="checkbox"/>	<input type="checkbox"/>
2 Are you having, have you had in the past year or since your last donation, any treatment from a doctor, dentist, nurse or any other healthcare professional?	<input type="checkbox"/>	<input type="checkbox"/>
3 Are you presently on any medication, even if not prescribed by a doctor? Have you ever had medications for acne, psoriasis, infertility or to replace Growth Hormone? Have you ever used medication to prevent HIV infection (PrEP/PEP, pre/post-exposure prophylaxis for HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
4 Over the past 2 weeks have you had a cold, allergies, fever, hay fever, or asthma? Have you recently needed to use any inhalers?	<input type="checkbox"/>	<input type="checkbox"/>
5 Have you had diarrhoea, or any other infection, over the past month?	<input type="checkbox"/>	<input type="checkbox"/>
6 Have you ever suffered from serious illnesses (e.g. heart, kidney, liver or lung problems, sexually transmitted diseases, haematological diseases, infectious or hereditary diseases, unexplained fever, jaundice, seizures or cancer)? Are you diabetic using insulin?	<input type="checkbox"/>	<input type="checkbox"/>
7 Have you ever suffered from chest pain, shortness of breath or fainting episodes, or had problems during or after giving blood or blood samples?	<input type="checkbox"/>	<input type="checkbox"/>
8 Have you ever needed to undergo an operation, endoscopy, or any other procedure in hospital? Have you undergone any procedure in the UK since 1 st January 1980? (UK includes England, Northern Ireland, Scotland, Wales, The Channel Islands and The Isle of Man.)	<input type="checkbox"/>	<input type="checkbox"/>
9 Have you had an organ, tissue or corneal transplant?	<input type="checkbox"/>	<input type="checkbox"/>
10 Have you ever, or since your last donation, received blood in Malta? Have you ever been transfused outside the Maltese Islands? Did you ever receive any plasma products or blood-derived coagulation factors?	<input type="checkbox"/>	<input type="checkbox"/>
11 (For women only) Is there any possibility that you are pregnant at present? Were you pregnant during the past 6 months or following your last blood donation?	<input type="checkbox"/>	<input type="checkbox"/>
12 Were you born outside the Maltese Islands? Have you ever lived abroad? Have you lived in the United Kingdom for a cumulative period of six months (or more) between 1980 and 1996? (UK includes England, Northern Ireland, Scotland, Wales, The Channel Islands & The Isle of Man.)	<input type="checkbox"/>	<input type="checkbox"/>
13 Have you had any vaccines during the past year?	<input type="checkbox"/>	<input type="checkbox"/>
14 Was your mother or maternal grandmother born in Mexico, Central or South America?	<input type="checkbox"/>	<input type="checkbox"/>
15 Have you been in close contact with a person with an infectious disease during the past year?	<input type="checkbox"/>	<input type="checkbox"/>
16 Have you ever been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?	<input type="checkbox"/>	<input type="checkbox"/>

LIFESTYLE	YES	NO
1 During the past 4 months, have you had acupuncture, piercing to any part of the body, tattoos, cosmetic treatment involving the use of needles, alternative invasive therapy (e.g. wet cupping), or suffered a needle-stick injury, a human bite or blood splash into your eyes/mouth?	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you ever used recreational drugs (including those for chemsex)? Are you dependent on alcohol or addicted to any drugs? Have you ever injected or been injected with any non-prescribed drugs (e.g. heroin, body-building drugs)? Have you ever snorted cocaine or any other drug?	<input type="checkbox"/>	<input type="checkbox"/>
3 a) During the past 4 months: <ul style="list-style-type: none"> i. Have you had a new sexual partner? ii. Did you have more than one sexual partner? iii. Did you purchase the services of a sex worker or were you ever involved in sex work yourself? iv. Were you sexually active in parts of the world where HIV is very common? 	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you had sex with a person who, within the last 4 months, falls within these categories? <ul style="list-style-type: none"> i. Had any other sexual contact with another person ii. Had a sexually transmitted infection including HIV, Hepatitis B, Hepatitis C, Syphilis or HTLV iii. Has purchased the services of a sex worker or were themselves involved in sex work iv. Had sexual activity in parts of the world where HIV is very common 	<input type="checkbox"/>	<input type="checkbox"/>
c) Has your partner ever made use of injected drugs?	<input type="checkbox"/>	<input type="checkbox"/>
4 a) Have you been travelling during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
b) Will you be travelling today/going on a long-haul flight over the next 3 days?	<input type="checkbox"/>	<input type="checkbox"/>
c) Has your partner/spouse travelled to a country with Zika transmission and been diagnosed with Zika infection in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
5 Do you have a hazardous occupation or hobby (e.g. work on ladders/scaffolding, heavy goods vehicle driving, bus driving, crane operating, piloting, scuba diving, or sky-diving)?	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for choosing to try to donate blood today. All the information you provide during the donor interview will be kept strictly confidential and none of it will be divulged to anyone without your permission.