



BLUTSPENDE SRK SCHWEIZ
TRANSFUSION CRS SUISSE
TRASFUSIONE CRS SVIZZERA

Chapter

Chapter 17 A1: Medical Questionnaire and Informed Consent

Effective : 01.11.2023

Version : 21

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Medical Questionnaire

Donation Number

You have just read the **information sheet for blood donors** and have declared your willingness to donate blood. Please answer the following questions truthfully by putting a cross in the Yes or No box, as appropriate. This will help considerably to minimise the remaining risks to your own safety and that of the patients who will receive your blood.

Consent form to be completed and signed by the donor:

- I hereby consent to donate my blood.
- I confirm by my signature that I have thoroughly read and understood all of the information sheet for blood donors and that any queries were satisfactorily answered.
- I confirm that my personal data are correct and that the answers to all questions are true and accurate.
- I consent that the blood I donate undergoes testing, which may include genetic methods if necessary, and that a sample of my blood will be stored for possible subsequent tests according to the Federal law on therapeutic products. I agree to be informed about abnormal results.
- I consent that part of my donation may be used for the preparation of medicinal products.
- Personal information given in connection with blood donation is subject to medical secrecy. It may only be used within Swiss Transfusion SRC (T-CH) and the Regional Blood Transfusion Service (RBTS). The Regional Blood Transfusion Service is legally obliged to respect the Data Protection Act and to report notifiable diseases to the authorities.

Name: **First name:** **Date of birth:** **Date:** **Signature:**

	Yes	No	Initials
1. Have you ever donated blood in the past? If so, give date of last donation _____ Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you weigh more than 50 kg (or 110 lbs)?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are you in good health at present?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you been treated by a dentist or dental hygienist in the past 14 days, e.g. had a dental filling procedure?	<input type="checkbox"/>	<input type="checkbox"/>	
5. During the past 4 weeks, have you received medical care, had a temperature of more than 38°C (or 100°F) or other minor illnesses such as diarrhea or colds?	<input type="checkbox"/>	<input type="checkbox"/>	
6. a) During the past 4 weeks, have you taken any medicine (tablets, injections, suppositories) – including without prescription? If so, which? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) During the past 4 weeks, have you taken medicine for prostate enlargement or hair loss (e.g. Alopecia®, Finacapil®, Propecia® or Proscar®) or acne (e.g. Roaccutan®, Curakne®, Isotretinoin®, Tretinac® or Toctino®)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) During the past 4 months, have you taken antiretroviral therapy /PEP/PrEP (e.g. Truvada®, Isentress® Prezista® or Norvir®)?	<input type="checkbox"/>	<input type="checkbox"/>	
d) During the past 6 months, have you taken Avodart® or Duodart® to treat prostate enlargement?	<input type="checkbox"/>	<input type="checkbox"/>	
e) During the past 3 years, have you taken Neotigason®, Acicutan® to treat psoriasis or Erivedge® to treat basal cell carcinoma)?	<input type="checkbox"/>	<input type="checkbox"/>	
f) During the past 12 months, have you received any blood-derived medications?	<input type="checkbox"/>	<input type="checkbox"/>	
7. a) Have you ever received any immunotherapy (cells or serum of human or animal origin)?	<input type="checkbox"/>	<input type="checkbox"/>	
b) During the past 12 months, have you been vaccinated to prevent rabies or tetanus?	<input type="checkbox"/>	<input type="checkbox"/>	
c) During the past 4 weeks, have you received any other vaccinations? If so, please specify _____ When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you ever had any of the health problems or disorders mentioned below?	<input type="checkbox"/>	<input type="checkbox"/>	
a) Cardiac/circulatory or lung disease (e.g. high/low blood pressure, heart attack, breathing difficulty, stroke, ministroke (TIA), loss of consciousness)?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Skin disease (e.g. wound, rash, eczema, fever blister) or allergy (e.g. hay fever, asthma, medicines)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Other diseases (diabetes, blood disease, coagulation disease, vascular disease, kidney disease, neurological disease, epilepsy, cancer, osteoporosis)?	<input type="checkbox"/>	<input type="checkbox"/>	
9. During the past 3 years or since your last blood donation, have you had <input type="checkbox"/> a hospital stay? <input type="checkbox"/> an accident? <input type="checkbox"/> surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
10. a) Have you ever received graft(s) of human or animal tissues or have you ever had an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you ever had any brain or spinal cord surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Before 1.1.1986, were you ever treated with growth hormones?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Have you or has any member of your family had confirmed or suspected Creutzfeldt-Jakob disease?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Between 1.1.1980 and 31.12.1996, did you ever stay for a total of 6 months or more in the United Kingdom (England, Wales, Scotland, Northern Ireland, Isle of Man, Channel Islands, Gibraltar and the Falkland Islands)?	<input type="checkbox"/>	<input type="checkbox"/>	



	Yes	No	Initials
f) Have you received a blood transfusions since 1.1.1980?	<input type="checkbox"/>	<input type="checkbox"/>	
11. a) During the past 12 months, did you travel outside Switzerland? If yes, where and how long? _____ When did you return to Switzerland? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) Did you have any signs of illness (e.g., fever) there or since your return? If yes, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
12. a) Were you born outside of Switzerland, did you grow up there or did you live there for 6 months or more? If yes, in which country? _____ If yes, since when have you lived in Switzerland? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) Was your mother born outside Europe, did she grow up there or did she live there for more than 6 months? If yes, in which country? _____	<input type="checkbox"/>	<input type="checkbox"/>	
13. a) Have you had in the last - 6 months: <input type="checkbox"/> toxoplasmosis <input type="checkbox"/> mononucleosis <input type="checkbox"/> amebiasis <input type="checkbox"/> shigellosis <input type="checkbox"/> TBE - 12 months: <input type="checkbox"/> Schistosomiasis <input type="checkbox"/> gonorrhoea - 2 years: <input type="checkbox"/> osteomyelitis <input type="checkbox"/> rheumatic fever <input type="checkbox"/> tuberculosis <input type="checkbox"/> relapsing fever <input type="checkbox"/> Guillain-Barré-Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you ever had any of the following infectious diseases: <input type="checkbox"/> malaria <input type="checkbox"/> Chagas disease <input type="checkbox"/> brucellosis <input type="checkbox"/> echinococcosis <input type="checkbox"/> leishmaniosis <input type="checkbox"/> lymphogranuloma venereum <input type="checkbox"/> filariasis <input type="checkbox"/> Q fever <input type="checkbox"/> babesiosis <input type="checkbox"/> Ebola <input type="checkbox"/> or other serious infections If yes, which? _____ When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
c) Have you had a tick bite in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Have you had contact with a person who has or had an infectious disease in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
14. During the past 4 months, have you undergone: <input type="checkbox"/> tattooing, <input type="checkbox"/> body piercing, <input type="checkbox"/> electric epilation, <input type="checkbox"/> cosmetic treatments (permanent make-up, microblading etc., <input type="checkbox"/> gastroscopy, colonoscopy, <input type="checkbox"/> acupuncture, <input type="checkbox"/> contact with foreign blood (a needle injury, blood splash hitting the eyes, mouth or another part of the body)? If so, when and where? _____	<input type="checkbox"/>	<input type="checkbox"/>	
15. Have you ever had jaundice (hepatitis) or a positive test for hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	
16. a) Do one or more of the following risk situations apply to you? • Have you changed your sexual partner in the past 4 months? • Have you had sexual contact (protected or unprotected) with more than two people in the past 4 months? • Have you had sexual contact under the influence of synthetic drugs in the past 12 months? • Have you had sexual contact for which you received money or other benefits (drugs or medication)? • Have you taken any drugs by injection? • Have you ever had a positive test for HIV (AIDS), syphilis or jaundice (hepatitis B or C)? • Has your life partner, sex partner or roommate contracted jaundice (hepatitis B or C) in the past 6 months? • Has your sexual partner contracted Zika in the past 3 months?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
b) During the past 12 months, have you had sexual intercourse with partners who: • were exposed to any of the risk situations listed in question 16a? c) During the past 4 months, have you had sexual intercourse with partner(s): • who have been in countries where HIV, hepatitis C (HCV), hepatitis B (HBV) is endemic for more than 6 months or have received blood transfusions there? If yes, date of return of the partner: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
17. To answer only by women: • Have you ever been pregnant? If yes, state the date of your last pregnancy _____ • Before 1.1.1986, did you receive hormone injections for infertility treatment?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

To be completed by RBTS SRC:

Remarks question _____ : _____
question _____ : _____
question _____ : _____

► Questionnaire and signature checked for completeness Date: _____ Initialed BTS: _____

► Eligibility to donate blood Yes

No Reason: _____ Date: _____ Initialed BTS: _____

IDENTITY & OTHER INFORMATION
(Regional data)