



REGISTRATION FOR BLOOD DONORS Thanks to present an identity document

Family name : First name(s) :

Date of birth : Gender : M F Birth name :

day month year

Address (specify the landlord) :
.....
.....

Zip code : Locality : Private tel. :

Prof. tel. :

Profession/employer : Mobile phone :

Attending doctor : Weight : Height in cm :

E-mail : visa
acc visa
inf

You have just read the **information sheet for blood donors**, which is at your disposal at the blood donation center and you think you are able to donate blood. We would be grateful if you could now answer the following questions with the greatest sincerity by ticking the box with a cross in the corresponding box. You will help to ensure to your own safety and that of the patients who will receive your blood.

- 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 I was provided with all the necessary explanations.
- I confirm that my personal data are correct and that the answers to all questions are true and accurate.
- I know and consent that the blood I donate undergoes biological 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 am aware and consent that part of my donation may be used for the production of medicinal products. I consent that my donation or certain components thereof may be used for medical research after encoding or anonymization.
- The personal data collected in the context of the blood donation is subject to medical confidentiality and used exclusively by Swiss Transfusion SRC (T-CH) and the Regional Blood Transfusion Service (RBTS). The RBTS is legally obliged to respect the Data Protection Act and to report notifiable diseases to the Health Authorities.

		Yes	No	Visa
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 currently in good health?	<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, please specify	<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®, Finacpil®, 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 HIV (e.g. Truvada®, Isentress®, Prezista® or Norvir®)?	<input type="checkbox"/>	<input type="checkbox"/>	
	d) During the past 6 months, have you taken medicine to treat prostate enlargement (e.g. Avodart®, Duodart®)?	<input type="checkbox"/>	<input type="checkbox"/>	
	e) During the past 3 years, have you taken Neotigason®, Acicutan® (treatment of psoriasis) or Erivedge® (treatment for 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 following symptoms or diseases?			
	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) Do you have a skin disease (e.g. wound, rash, eczema, fever blister) or allergy (e.g. hay fever, asthma, medicines)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Do you have any other reportable diseases (e.g. diabetes, blood disease, coagulation disease, vascular disease, kidney disease, neurological disease, epilepsy, cancer, nervous breakdown, 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"/>	

		Yes	No	Visa
10.	c) Before 01.01.1986, have you ever been 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 01.01.1980 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"/>	
	f) Have you ever received one or more blood transfusions since 01.01.1980?	<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 clinical symptoms (e.g. fever) during your stay abroad 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 ever had any of the following diseases: If so, specify when? <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Amebiasis <input type="checkbox"/> Shigellosis <input type="checkbox"/> TBE <input type="checkbox"/> Schistosomiasis <input type="checkbox"/> Gonorrhoea <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 diseases: If so, specify when? <input type="checkbox"/> Malaria <input type="checkbox"/> Chagas disease <input type="checkbox"/> Brucellosis <input type="checkbox"/> Echinococcosis <input type="checkbox"/> Leishmaniasis <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?	<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 past 4 weeks? If yes, please specify:	<input type="checkbox"/>	<input type="checkbox"/>	
14.	During the past 4 months, have you undergone: <input type="checkbox"/> tattooing <input type="checkbox"/> gastroscopy, colonoscopy <input type="checkbox"/> body piercing <input type="checkbox"/> acupuncture <input type="checkbox"/> electric epilation <input type="checkbox"/> cosmetic treatments (permanent make-up, microblading, etc) <input type="checkbox"/> contact with foreign blood (a stitch wound, blood splash hitting the eyes, mouth or another part of the body)? If so, specify 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) Have you changed your sexual partner in the past 4 months?	<input type="checkbox"/>	<input type="checkbox"/>	
	b) Have you had sexual intercourse (protected or unprotected) with more than two people (partners) in the past 4 months?	<input type="checkbox"/>	<input type="checkbox"/>	
	c) Have you had sexual contact under the influence of synthetic drugs in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
	d) Have you had sexual contact for which you received money or other benefits (drugs or medication) in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
	e) Have you taken drugs by injection?	<input type="checkbox"/>	<input type="checkbox"/>	
	f) Have you ever had a positive test for HIV (AIDS), syphilis or jaundice (hepatitis B or C)	<input type="checkbox"/>	<input type="checkbox"/>	
17.	a) Has your life partner, sex partner or roommate contracted jaundice (hepatitis B or C) in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
	b) Has your sexual partner contracted Zika in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	
18.	a) During the past 12 months, have you had sexual intercourse with partners who were exposed to any of the risk situations listed in questions 16 and/or 17?	<input type="checkbox"/>	<input type="checkbox"/>	
	b) 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"/>	
19.	a) <i>Women only:</i> Have you ever been pregnant? If yes, state the date of your last pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	
	b) Before 01.01.1986, did you receive hormone injections for infertility treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Date	Name/First name	Date of birth	Signature	

Réservé au Centre de Transfusion Sanguine			KAP17A1V21- 1 ^{er} nov. 2023 – 4.1.FO.0231-v7.1	
Q no :	Avis médical :			
Q no :				
Q no :				
Q contrôlé / apte au don : OUI <input type="checkbox"/> Type de don :				
NON <input type="checkbox"/> Raison :				
Analyses :	Visa médecin			
Date visa	Pouls	TA	MCP	Group
Hb capillaire visa	Durée prélèvement	Heure fin	Visa ponct	Equipement
no prélèvement	Commentaire prélèvement			
coller ici				Visa fin