CAPE COD HOSPITAL

NICHOLAS G. XIAHROS BLOOD DONOR CENTER
Hyannis, MA 02601 • FDA Registration Number 1274247

Affix Barcode here

☐ Chagas ☐ Platelet
☐ Type Card ☐ HLA
☐ ID Checked

DONOR CARD # ______________________

Last Name: ____________________________ **First Name:** ____________________________ **Middle Name:** __________
(Please Print)

Donated under a different name(s) with CCHC: Yes ☐ **No** ☐
If yes please list name(s) used (Please Print)
Name ____

DOB: __________________ **Male** ☐ **Female** ☐

Telephone #: ______________________________

Cell Phone #: ______________________________

E-mail: ______________________________

Mailing Address: ______________________________

City: ______________________________

State: ____________ **Zip:** ______________

Weight: ____________________ **(Min. 110 lbs.)**

RELEASE: I voluntarily donate my blood to Cape Cod Hospital to use as necessary. I have answered all the questions accurately and I understand that my answers are important in determining my eligibility to donate blood. I understand that my blood will be tested for laboratory evidence of certain infectious agents capable of being spread through blood transfusion, including, but not limited to, HIV, hepatitis, and other clinically important agents, and that I will be informed of an abnormal result (There may be some circumstances in which some or all of this testing cannot be performed). I understand that investigational testing may be performed on my blood. If this testing indicates that I should no longer donate blood, I understand that my name will be placed on a list of indefinitely deferred donors and in some instances donor information, including test results, may be reported to state or local health departments. This procedure has been explained to me by Blood Donor Service staff. I understand that I have the opportunity to request further explanation from a physician.

Signed: ____ Date: ____________________

Witness / Identification verified by staff: ____

DO NOT WRITE BELOW THIS LINE. GO TO NEXT PAGE.

Copy

Hemoglobin: __________ g/dl Device: # __________
F: 12.5 ≤ 18.0 g/dl
M: 13.0 ≤ 18.0 g/dl

Temperature: __________ (≤ 99.5°F)

Blood Pressure: ____________ / ____________ mmHg
Systolic: 90-180 mmHg Diastolic: 50-100 mmHg

Inspection of both arms:
Acceptable ☐ Unacceptable ☐

Pulse: ________ Beats/Min. ☐ Regular ☐ Irregular
50-100 Beats/Min with <10 Irregular Beats/Min

Performed by: ______________________________

Phlebotomy - ☐ Satisfactory ☐ Unsatisfactory

Donor Reaction - ☐ None ☐ Mild ☐ DAER Completed
☐ Moderate ☐ Severe

1ST DRAW

Phlebotomist: ______________________ Date: ______________ Arm: L or R

Start Time: ____________________ End Time: ____________________ Volume: ______________

Length of Draw: ______________ Scale: ________ Lot #: ______________________ Exp: __________

- -

Phlebotomy - ☐ Satisfactory ☐ Unsatisfactory

Donor Reaction - ☐ None ☐ Mild ☐ DAER Completed
☐ Moderate ☐ Severe

2ND DRAW

Phlebotomist: ____________________ Date: ______________________ Arm: L or R

Start Time: ____________________ End Time: ____________________ Volume: ______________

Length of Draw: ______________ Scale: ________ Lot #: ______________________ Exp: __________

Peer Review ______________________________ Final Record Review ______________________________

Donation Site: ______________________________

DONOR TO COMPLETE

Affix Barcode here

Donor Card #_____

	Yes	No
Are you		
1. Feeling healthy and well today?	☐	☐
2. Currently taking an antibiotic?	☐	☐
3. Currently taking any other medication for an infection?	☐	☐
4. Have you taken any medications on the Medication Deferral List in the time frames indicated? (Review the Medication Deferral List.)	☐	☐
5. Have you read the educational materials today?	☐	☐
In the past 48 hours,		
6. Have you taken aspirin or anything that has aspirin in it?	☐	☐
In the past 8 weeks, have you		
7. Donated blood, platelets or plasma?	☐	☐
8. Had any vaccinations or other shots?	☐	☐
9. Had contact with someone who was vaccinated for smallpox in the past 8 weeks?	☐	☐
In the past 3 months, have you		
10. Had a blood transfusion?	☐	☐
11. Had a transplant such as organ, tissue, or bone marrow?	☐	☐
12. Had a graft such as bone or skin?	☐	☐
13. Come into contact with someone else's blood?	☐	☐
14. Had an accidental needle-stick?	☐	☐
15. Had sexual contact with anyone who has ever had HIV/AIDS or has ever had a positive test for the HIV/AIDS virus?	☐	☐
16. Had sexual contact with a prostitute or anyone else who has ever taken money or drugs or other payment for sex?	☐	☐
17. Had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything not prescribed by their doctor?	☐	☐
18. Male donors: Had sexual contact with another male? ☐ I am a female	☐	☐
19. Female donors: Had sexual contact with a male who had sexual contact with another male in the past 3 months? ☐ I am a male	☐	☐
20. Had a tattoo?	☐	☐
21. Had ear or body piercing?	☐	☐
22. Had or been treated for syphilis or gonorrhea?	☐	☐
23. Used needles to take drugs, steroids, or anything not prescribed by your doctor?	☐	☐
24. Received money, drugs, or other payment for sex?	☐	☐
In the past 16 weeks,		
25. Have you donated a double unit of red cells using an apheresis machine?	☐	☐

Copy

DONOR TO COMPLETE

	Yes	No
In the 12 months, have you		
26. Had sexual contact with a person who has hepatitis?	☐	☐
27. Lived with a person who has hepatitis?	☐	☐
28. Been in juvenile detention, lockup, jail, or prison for 72 hours or more consecutively?	☐	☐
In the past 3 years, have you		
29. Been outside the United States or Canada?	☐	☐
From 1980 through 1996,		
30. Did you spend time that adds up to 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		
31. 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 through present, did you		
32. 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		
33. Female donors: Been pregnant or are you pregnant now? ☐ I am a male	☐	☐
34. Had a positive test for the HIV/AIDS virus?	☐	☐
35. Had malaria?	☐	☐
36. Received a dura mater (or brain covering) graft or xenotransplantation product?	☐	☐
37. Had any type of cancer, including leukemia?	☐	☐
38. Had any problems with your heart or lungs?	☐	☐
39. Had a bleeding condition or a blood disease?	☐	☐
40 Had a positive test result for Babesia?	☐	☐
Have you		
41. Had a tick bite in the past 4 weeks?	☐	☐
42. Been under a doctor's care for anything other than routine check-ups?	☐	☐
43. In the past 3 months, have you taken any medication to prevent an HIV infection?	☐	☐
44. Have you EVER taken any medication to treat an HIV infection?	☐	☐

Copy

BELOW FOR STAFF USE ONLY

Comments