



REGISTRATION FOR BLOOD DONORS thanks to present an identify document

Family name :		First name(s) :						
Birth name :		Date of birth : <table border="1" style="display:inline-table; width:100px; height:20px; vertical-align:middle;"> <tr> <td style="width:33%; text-align:center;">day</td> <td style="width:33%; text-align:center;">month</td> <td style="width:33%; text-align:center;">year</td> </tr> </table>	day	month	year	Gender : <table border="1" style="display:inline-table; width:40px; height:20px; vertical-align:middle;"> <tr> <td style="width:50%; text-align:center;">M</td> <td style="width:50%; text-align:center;">F</td> </tr> </table>	M	F
day	month	year						
M	F							
Address (specify the landlord) :								
Zip code :		Locality :						
Profession/employer :		Tel. private :						
Family doctor :		Tel. prof. :						
E-mail :		Tel mobile :						
Weight :		Height in cm :						
		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 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.

- 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 am aware that part of my donation may be used for the preparation of medicinal products.
- I furthermore consent that my donation or certain components thereof may be used for medical research after encoding or anonymization.
- Personal information given in connection with blood donation is subject to medical secrecy. It may only be used within Swiss Transfusion SRC (T-CH-SRC) and the Regional Blood Transfusion Service SRC (RBTS SRC).
The Regional Blood Transfusion Service is legally obliged to report notifiable diseases to the 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 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 72 hours (3 days)?	<input type="checkbox"/>	<input type="checkbox"/>	
5.	During the past 4 weeks, have you received medical care or had a temperature of more than 38°C (or 100°F)?	<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®, Finpecia®, Propecia® or Proscar®) or acne (e.g. Roaccutan®, Curakne®, Isotretinoin®, Tretinac® or Toctino®)?	<input type="checkbox"/>	<input type="checkbox"/>	
	c) During the past 6 months, have you taken medicine to treat prostate enlargement (e.g. Avodart®, Duodart®)?	<input type="checkbox"/>	<input type="checkbox"/>	
	d) 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"/>	
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?			
	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) or allergy (e.g. hay fever, asthma, medicines)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Other diseases (e.g. diabetes, blood disease, coagulation disease, vascular disease, kidney disease, neurological disease, epilepsy, cancer)?	<input type="checkbox"/>	<input type="checkbox"/>		
9.	During the past 3 years or since your last blood donation, have you had <input type="checkbox"/> an illness? <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, 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 01.01.1980 and 31.12.1996, did you ever stay for a total of 6 months or more in the United Kingdom (UK) (England, Wales, Scotland, Northern Ireland, Isle of Man, Channel Islands, Gibraltar and the Falkland Islands)?	<input type="checkbox"/>	<input type="checkbox"/>	
	f) Have you received one or more blood transfusions since 01.01.1980?	<input type="checkbox"/>	<input type="checkbox"/>	
11.	a) During the past 6 months, did you travel outside Switzerland? If yes, where? 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.	Were you born outside Europe, did you grow up there or did you live there for 6 months or more? a) If yes, in which country? If yes, since when have you lived in Europe?	<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.	Have you had any of the following diseases: If so, when?	<input type="checkbox"/>	<input type="checkbox"/>	
	a) <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"/> Telapsing 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, when?	<input type="checkbox"/>	<input type="checkbox"/>	
	c) <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"/>	<input type="checkbox"/>	
	c) Have you ever had another serious infectious disease? If yes, which? When?	<input type="checkbox"/>	<input type="checkbox"/>	
	d) Have you had a tick bite or been in contact with infectious diseases 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"/> permanent make-up, <input type="checkbox"/> contact with foreign blood (a stitch wound, blood splash hitting the eyes, mouth or another part of the body)? If so, when?	<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.	Has anyone in your family circle or your usual sexual partner had jaundice (hepatitis) or a Zika infection during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
17.	Have you been exposed to any of the following risk situations?			
	a) Change of sexual partner in the past 4 months	<input type="checkbox"/>	<input type="checkbox"/>	
	b) Sexual intercourse (with or without protection) with several partners in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	
	c) During the past 12 months, stayed for 6 months or longer in countries with a high HIV rate	<input type="checkbox"/>	<input type="checkbox"/>	
	d) Sexual intercourse for money, drugs or medication	<input type="checkbox"/>	<input type="checkbox"/>	
	e) Drug injection at present or in the past	<input type="checkbox"/>	<input type="checkbox"/>	
	f) Positive test for HIV (AIDS), syphilis or jaundice (hepatitis B or C)	<input type="checkbox"/>	<input type="checkbox"/>	
	g) Men only: Sexual intercourse between men ever in the past	<input type="checkbox"/>	<input type="checkbox"/>	
	h) Sexual intercourse between men in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	
18.	During the past 12 months, have you had sexual intercourse with partners who			
	a) were exposed to any of the risk situations listed in question 17	<input type="checkbox"/>	<input type="checkbox"/>	
	b) received blood transfusions in countries where HIV is epidemic	<input type="checkbox"/>	<input type="checkbox"/>	
19.	a) Women only: 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	
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Réservé au Centre de Transfusion Sanguine		KAP17A1V16- 1 ^{er} fév. 2019 – 4.1.FO.0231-v.3.1			
Q no :		Avis médical : visa médecin			
Q no :					
Q no :					
Q contrôlé / apte au don : OUI <input type="checkbox"/> Type de don : NON <input type="checkbox"/> Raison :					
Analyses :					
date visa	Pouls	TA	MCP	Gr	
Hb/Ht visa	T	H	visa ponct	B	
no prélèvement	commentaire prélèvement				
coller ici					visa fin