Hôpitaux Universitaires Genève

Centre de Transfusion Sanguine
Rue Gabrielle-Perret-Gentil 6, 1205 Genève
Accueil.Donneurs@hcuge.ch www.dondusang.ch
T.+41(0)22 372 39 01

Opening hours:
Monday, Tuesday, Wednesday, Friday 7.30 - 15.00
Thursday 11.00 - 19.00
1st & 3rd Saturday of the month 8.30 - 12.00

REGISTRATION FOR BLOOD DONORS

Thanks to present an identity document

Family name : ..... First name(s) :.....

Date of birth : ☐☐ ☐☐ ☐☐☐☐ (day / month / year) Gender : M F Birth name : .....

Address (specify the landlord) :

.. ..

..... Private tel. : .....

Zip code : ..... Locality : ..... 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 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 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 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? ……..……	☐	☐	
2.		Do you weigh more than 50 kg (or 110 lbs)?	☐	☐	
3.		Are you currently in good health?	☐	☐	
4.		During the past 7 days, have you been treated by a dentist or dental hygienist?	☐	☐	
5.		During the past 4 weeks, have you received medical care or had a fever above 38°C (or 100°F)?	☐	☐	
6.	a)	During the past 4 weeks, have you taken any medicine (tablets, injections, suppositories) – including without prescription? If so, please specify ……..	☐	☐	
	b)	During the past 4 weeks, have you taken medicine for prostate enlargement or hair loss (e.g. Alocapil®, Finacapil®, Propecia® or Proscar®) or acne (e.g. Roaccutan®, Curakne®, Isotretinoin®, Tretinac® or Toctino®)?	☐	☐	
	c)	During the past 4 months, have you taken antiretroviral therapy HIV (e.g. Truvada®, Isentress®, Prezista®/Norvir®)?	☐	☐	
	d)	During the past 6 months, have you taken medicine to treat prostate enlargement (e.g. Avodart®, Duodart®)?	☐	☐	
	e)	During the past 3 years, have you taken Neotigason®, Acicutan® (treatment of psoriasis) or Erivedge® (treatment for basal cell carcinoma)?	☐	☐	
	f)	During the past 12 months, have you received any blood-derived medications?	☐	☐	
7.	a)	Have you ever received any immunotherapy (cells or serum of human or animal origin)?	☐	☐	
	b)	During the past 12 months, have you been vaccinated to prevent rabies or tetanus?	☐	☐	
	c)	During the past 4 weeks, have you received any other vaccinations? If so, please specify ……. When? ……..	☐	☐	
8.	a)	Have you ever had any of the following symptoms or diseases? Cardiac/circulatory or lung disease (e.g. high/low blood pressure, heart attack, breathing difficulty, stroke, ministroke (TIA), loss of consciousness)?	☐	☐	
	b)	Do you have a skin disease (e.g. wound, rash, eczema, fever blister) or allergy (e.g. hay fever, asthma, medicines)?	☐	☐	
	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)?	☐	☐	
9.		During the past 3 years or since your last blood donation, have you had ☐ a hospital stay? ☐ an accident? ☐ surgery?	☐	☐	
10.	a)	Have you ever received graft(s) of human or animal tissues or have you ever had an organ transplant?	☐	☐	
	b)	Have you ever had any brain or spinal cord surgery?	☐	☐	

			Yes	No	visa
10.	c)	Before 01.01.1986, have you ever been treated with growth hormones?	☐	☐	
	d)	Have you or has any member of your family had confirmed or suspected Creutzfeldt-Jakob disease?	☐	☐	
	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)?	☐	☐	
	f)	Have you ever received one or more blood transfusions since 01.01.1980?	☐	☐	
11.	a)	During the past 12 months, did you travel outside Switzerland? If yes, where and how long? …… When did you return to Switzerland? ……	☐	☐	
	b)	Did you have any clinical symptoms (e.g. fever) during your stay abroad or since your return? If yes, please specify: ……	☐	☐	
	c)	Did you have any medical or paramedical intervention there? If yes, please specify: ……	☐	☐	
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? ……	☐	☐	
	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? ……	☐	☐	
13.	a)	Have you ever had any of the following diseases: If so, specify when? …… ☐ Toxoplasmosis ☐ Mononucleosis ☐ Amebiasis ☐ Shigellosis ☐ TBE ☐ Schistosomiasis ☐ Gonorrhoea ☐ Osteomyelitis ☐ Rheumatic fever ☐ Tuberculosis ☐ Relapsing fever ☐ Guillain-Barré-Syndrome	☐	☐	
	b)	Have you ever had any of the following diseases: If so, specify when? …… ☐ Malaria ☐ Chagas disease, ☐ Brucellosis, ☐ Echinococcosis, ☐ Leishmaniasis, ☐ Lymphogranuloma venereum, ☐ Filariasis, ☐ Q Fever, ☐ Babesiosis, ☐ Ebola	☐	☐	
	c)	Have you ever had another serious infectious disease? If yes, which? ..... When? ……	☐	☐	
	d)	Have you had a tick bite or been in contact with infectious diseases in the past 4 weeks? If yes, please specify: ……	☐	☐	
14.		During the past 4 months, have you undergone: ☐ tattooing ☐ gastroscopy, colonoscopy ☐ body piercing ☐ acupuncture ☐ electric epilation ☐ cosmetic treatments (permanent make-up, microblading, etc) ☐ 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? ……	☐	☐	
15.		Have you ever had jaundice (hepatitis) or a positive test for hepatitis?	☐	☐	
16.		Has anyone in your family circle or roommate or your usual sexual partner had jaundice (hepatitis) during the past 6 months or a Zika infection during the past 3 months?	☐	☐	
17.		Have you been exposed to any of the following risk situations?			
	a)	Change of sexual partner in the past 4 months	☐	☐	
	b)	Sexual intercourse (with or without protection) with alternating partners (more than two) in the past 4 months	☐	☐	
	c)	During the past 12 months, sexual intercourse under the influence of synthetic drugs	☐	☐	
	d)	During the past 12 months, sexual intercourse for money, drugs or medication	☐	☐	
	e)	Drug injection at present or in the past	☐	☐	
	f)	Positive test for HIV (AIDS), syphilis or jaundice (hepatitis B or C)	☐	☐	
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 question 17?	☐	☐	
	b)	During the past 4 months, have you had sexual intercourse with partner(s), who have been in countries where HIV-HCV-HBV is endemic for more than 6 months or have received blood transfusions there? If yes, date of return of the partner: ……	☐	☐	
19.	a)	*Men only*: Sexual intercourse between men ever in the past	☐	☐	
	b)	Sexual intercourse between men in the past 12 months	☐	☐	
20.	a)	*Women only*: Have you ever been pregnant? If yes, state the date of your last pregnancy ……	☐	☐	
	b)	Before 01.01.1986, did you receive hormone injections for infertility treatment?	☐	☐	

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

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Réservé au Centre de Transfusion Sanguine

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Q no : .....

Q no : .....

Q no : .....

Q contrôlé / apte au don : OUI ☐ Type de don : ……..

NON ☐ Raison : .....

Analyses : .....

Avis médical :

Visa médecin

Date visa	Pouls	TA	MCP	Group
Hb capillaire visa	Durée prélèvement	Heure fin	Visa ponct	Equipement

no prélèvement coller ici	Commentaire prélèvement	Visa fin