

REGISTRATION FOR BLOOD DONORS Thanks to present an identity document

Family name : First name(s) :

Date of birth :

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 Gender :

M	F
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 Birth name :
day month year please CIRCLE the answer

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
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visa	inf
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You have just read the **information sheet for blood donors ANH Art.7.11**, 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 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 preparation of medicinal products.
I also agree that a portion (a few milliliters) of my donation may be used for method validation or medical research after final anonymization.
- Personal information given in connection with blood donation is subject to medical secrecy. It may be used within 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. Only coded information (donor and product numbers) and blood group characteristics are passed on for patient care.

		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.	Have you been treated by a dentist or dental hygienist in the past 14 days, e.g. had a dental filling procedure?	☐	☐	
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?	☐	☐	
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. Proscar®, Finasterid-Mepha Procapil®, Finacapil® or Propecia®) or acne/eczema (e.g. Roaccutan®, Curakne®, Isotretinoin®, Tretinac® or Tactino®) or for depression (lithium-containing medications, e.g. Lithiofor®) or migraine (e.g. Topamax®) or bipolar disorder (e.g. Convulex® or Tegretol®)?	☐	☐	
	c) Have you injected any medication for endometriosis (e.g. Lucrin Depot®) in the last 2 months?	☐	☐	
	d) During the past 4 months, have you taken antiretroviral therapy PEP/PrEP (e.g. Truvada®, Isentress®, Prezista® or Norvir®) or received any blood-derived medications?	☐	☐	
	e) During the past 6 months, have you received cytostatic drugs (e.g. methotrexate against psoriasis or arthritis)?	☐	☐	
	f) During the past 6 months, have you taken Avodart® or Duodart® to treat prostate enlargement?	☐	☐	
	g) During the past 3 years, have you taken Neotigason®, Acicutan® to treat psoriasis or Erivedge® to treat basal cell carcinoma?	☐	☐	
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.	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)?	☐	☐	
	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, osteoporosis)?	☐	☐	

		Yes	No	Visa
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 abroad?	☐	☐	
	c) Before 01.01.1986, have you ever been treated with growth hormones or have received hormone injections for the treatment of infertility?	☐	☐	
	d) Have you or has any member of your family had confirmed or suspected Creutzfeldt-Jakob disease?	☐	☐	
	e) During the past 4 months, or since your last blood donation have you received a blood transfusion?	☐	☐	
11.	a) During the past 6 months, did you travel outside Switzerland? If yes, where and how long? When did you return to Switzerland?	☐	☐	
	b) Did you have any signs of illness (e.g. fever) there or since your return? If yes, please specify:	☐	☐	
12.	Were you born outside of Switzerland, 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 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.	Have you ever had any of the following diseases: If so, specify when?	☐	☐	
	a) ☐ Toxoplasmosis ☐ Mononucleosis ☐ Amebiasis ☐ Shigellosis ☐ TBE ☐ Schistosomiasis ☐ Gonorrhoea ☐ Osteomyelitis ☐ Rheumatic fever ☐ Tuberculosis ☐ Relapsing fever ☐ Guillain-Barré-Syndrome ☐ Q Fever			
	b) Have you ever had any of the following diseases: If so, specify when?	☐	☐	
	☐ Malaria ☐ Chagas disease ☐ Brucellosis ☐ Echinococcosis ☐ Leishmaniasis ☐ Lymphogranuloma venereum ☐ Filariasis ☐ Babesiosis ☐ Ebola ☐ or other serious infections If yes, which?			
	c) Have you had a tick bite in the past 4 weeks?	☐	☐	
	d) Have you had contact with a person who has or had an infectious disease in the last 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) ☐ leech therapy ☐ contact with foreign blood (a needle injury, blood splash hitting the eyes, mouth or another part of the body)? If so, specify when and where?	☐	☐	
15.	Do one or more of the following risk situations apply to you?			
	a) Have you changed your sexual partner in the past 4 months?	☐	☐	
	b) Have you had sexual intercourse (protected or unprotected) with more than two people (partners) in the past 4 months?	☐	☐	
	c) Have you had sexual contact under the influence of synthetic drugs in the past 12 months?	☐	☐	
	d) Have you had sexual contact for which you received money or other benefits (drugs or medication) in the past 12 months?	☐	☐	
	e) Have you taken drugs by injection?	☐	☐	
	f) Have you ever had a positive test for HIV (AIDS) or jaundice (hepatitis B or C), or have you ever tested positive for these diseases?	☐	☐	
	g) Have you ever had syphilis?	☐	☐	
16.	a) Has your life partner, sex partner or roommate contracted jaundice (hepatitis B or C) in the past 6 months?	☐	☐	
	b) Has your sexual partner contracted Zika in the past 3 months?	☐	☐	
17.	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 15 and/or 16?	☐	☐	
	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:	☐	☐	
18.	If applicable to you: Have you ever been pregnant? If yes, state the date of your last pregnancy	☐	☐	
Date	Name/First name	Date of birth	Signature	
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Réservé au Centre de Transfusion Sanguine		ANH-Art7.9v3 - 1 ^{er} fév. 2026 – 4.1.FO.0231-v9.0		
Q no :	Avis médical :			
Q no :				
Q no :				
Q contrôlé / apte au don : OUI ☐ Type de don : NON ☐ 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