ABMDR Donor Application Form (2014)

Place the bar code here:

Please print clearly and fill in all applicable information

Personal Details										
Surname (Last)					First Name					
Date of Birth	Month	Day	Year	Age (yrs.)	Gender		**Today's date**	Month	Day	Year
	/	/			Male	Female		/	/	
Address:	Street No. and name		Apt#		City		State		Zip Code	
Home Tel.# ( )		Mobile Tel. # ( )			E-mail address:					
Driver's License #					Other					

Employment Details					
Name				Work Tel. ( )	
Address: Street No. and name		Apt#	City	State	Zip Code

Ethnic/Geographic Origin	
Donor's citizenship Donor's ethnicity Donor's place of birth	Mother: Mother's mother: Mother's father:
	Father: Father's mother: Father's father:

Spouse Details **Not Applicable** ☐		
Surname	Name	
Work Tel. No ( )	Mobile Tel. No ( )	E-mail address

1st Contact Details **Relationship code** **1-Parent** **2-Sibling** **3-Child** **4-Other Relative** **5-Friend**		
Surname	Name	Code
Work Tel. No ( )	Mobile Tel. No ( )	E-mail address

2nd Contact Details **Relationship code** **1-Parent** **2-Sibling** **3-Child** **4-Other Relative** **5-Friend**		
Surname	Name	Code
Work Tel. No ( )	Mobile Tel. No ( )	E-mail address

Medical Evaluation

Your answers to all questions are confidential. This medical evaluation below is designed to protect you, as well as safeguard the patient who might receive your blood stem cells. Although you may be medically suitable at this time, you may become medically unable to donate in the future.

Weight ___ Lbs	Height ft.____ in._

Please answer to each question in all boxes	Yes	No	*Have you ever had a serious illness such as:*	Yes	No
Are you in a good health?			**- Cancer of any kind including leukemia**		
Have you been a blood donor in the past?			**- Anemia or any blood disorder, bleeding disorders**		
Have you ever been turned down as a blood donor?			**- Malaria, (yellow) jaundice, or hepatitis**		
Have you ever had neck, back or spine problems?			**- Liver, kidney, lung problems including tuberculosis**		
Have you ever had serious illness, operation or been admitted to hospital?			**- Bowel, stomach and duodenal disease, including ulcer**		
In the last 12 months have you received injections or had a blood or blood products transfusion?			**- Significant or life threatening allergies**		
In the last 12 months have you had chest pain/angina or an irregular heartbeat?			**- Sleep apnea or shortness of breath or breathing problems including asthma**		
In the last 12 months have you been unwell, seen a doctor, or taking any medications?			**- Diabetes, a thyroid disorder or an autoimmune disease e.g. lupus or rheumatoid arthritis**		
Have you ever received a solid organ, marrow or stem cell transplant?			**- Blood pressure problems, heart disease including heart attack, heart surgery, heart related chest pains**		
Do you know anyone in your family who had or has leukemia or any other blood disorder?			**-Sexually transmitted disease (STD), e.g. gonorrhea or syphilis**		
Have you ever had a test which showed you had hepatitis B, hepatitis C, or HIV?			**Clinical depression necessitating medication**		

Explanation for "Yes" responses (*office representative's guidance might be needed*):

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Women only – **Are you pregnant or breastfeeding or have been pregnant in the last 9 months?** **Yes** ☐ **NO** ☐

How many times have you been pregnant? ☐ **How many children have you given birth to?** ☐

PLEASE READ BEFORE YOU SIGN THE APPLICATION

I have read this form and consent to its terms. I have also read educational materials (donor brochures, etc) provided. I have provided accurate health information about myself. I have had the opportunity to ask questions, and my questions have been discussed and answered to my satisfaction.

My signature below indicates, that:

1. **I acknowledge the volunteer nature of my participation and understand that I will not be paid for the donation, except reimbursement of all reasonable expenditures associated with the donation (travel, accommodation, etc).**
2. **I consent to donate to any patient in the world, and to have the right to withdraw at any time prior to donation.**
3. **I consent, if found to be a suitable match for a patient, to submit to a physical examination and to provide further blood samples for testing, including infectious disease markers.**
4. **I consent to have my blood, DNA and/or other relevant information used for quality assurance purposes, and for the purpose of ethically approved research.**
5. **I consent to have my personal and confidential information, collected by ABMDR, be used only for purposes related to authorized transplantation programs, in compliance with requirements of national and international laws, regulations and privacy acts.**
6. **I understand that the Registry keeps relevant donor/patient information anonymous both for donor and patient.**

Donor's signature ______________________________ **Date:** ______________________

Where the donor recruitment is held:

Evaluator's signature ______________________________ **Date:** ______________________

Swabber's signature ______________________________ **Date:**______________________