लायन्स ब्लड सेन्टर

LBC/DOC/NUR/001.1/Rev-2

(Regional Blood Transfusion Centre (North - West), SBTC, DELHI) Licence No. 1899

100% VOLUNTARY BLOOD DONATION

ए.के.-100, शालीमार बाग, दिल्ली-110088

रक्तदाता पंजीकरण सहमति एवं जाँच प्रपत्र

बैग टाइप		
DB 350 ☐	DB 450 ☐	QB ☐
TB 350 ☐	TB 450 ☐	ITB ☐

सेगमेन्ट नम्बर

लोट नम्बर

रक्तदाता आई.डी

कैम्प का नाम

दिनांक

समय घन्टे मिनट

कृपया नीले पैन से साफ-साफ लिखें ✓ / ✗ अथवा का निशान लगायें

रक्तदाता का नाम

उम्र वर्ष लिंग पुरुष ☐ स्त्री ☐ अन्य ☐ व्यवसाय

जन्म तिथि दिनांक माह वर्ष

नागरिकता भारतीय ☐ अन्य ☐

विवाहित ☐ अविवाहित ☐

पिता/पति का नाम

पता

पिन कोड

मोबाइल नं.

कार्यालय दूरभाष कोड के साथ

निवास दूरभाष कोड के साथ

ई-मेल

आपका ब्लड ग्रुप यदि जानते है A ☐ B ☐ AB ☐ O ☐ POS. ☐ NEG. ☐ नहीं जानते ☐

रक्तदान से पहले उपबोधन किया गया -

कृपया सही एवं सम्पूर्ण जानकारी दें। आपके द्वारा दी गई जानकारी आपकी और रक्तग्राही की सुरक्षा सुनिश्चित करती है। यदि आपकी मैडिकल कंडीशन इस प्रपत्र में सम्मिलित नहीं है तो कृपया काउन्सलर/डाक्टर को अवश्य बतायें। यह सूचना गोपनीय रखी जायेगी। धन्यवाद!

क्या आपने पहले रक्तदान किया है? ☐ हाँ ☐ नहीं

यदि हाँ, तो पिछले रक्तदान की दिनांक .....

क्या आप भविष्य में भी रक्तदान करना चाहते हैं? ☐ हाँ ☐ नहीं

यदि हाँ, तो कितने अन्तराल पर ☐ तीन माह ☐ छः माह ☐ वार्षिक

क्या आपको कभी रक्तदान के लिए अयोग्य घोषित किया गया है, यदि हाँ तो कारण .....

क्या आपको रक्तदान के बाद कोई परेशानी हुई है? ☐ हाँ ☐ नहीं

क्या आप स्वस्थ महसूस कर रहे हैं? ☐ हाँ ☐ नहीं

क्या आपने पिछले चार घंटों में कुछ खाया हैं? ☐ हाँ ☐ नहीं

क्या आप रात को आराम से सोये थे? ☐ हाँ ☐ नहीं

कृ.पृ.प.

जो लागू हो उस पर (✔) का निशान लगाये। अन्यथा (✖) का।

1) क्या आज आप स्वस्थ महसूस कर रहे है?	10) क्या आपको वर्तमान में या पूर्व में निम्न समस्या हुई है? - लिम्फनोड फूलना - अकारण भार कम होना, बुखार रहना - मधुमेह, उच्च रक्तचाप - दमा, मिर्गी, शिजोफ्रेनिया - कुष्ठ, त्वाचा विकार - यौन जनित रोग		15) क्या आपने पूर्व में कोई वैक्सीन ली है? (रैबिज, टिटैनस, टायफड, कोलेरा इत्यादि
2) क्या आपने नाश्ता या भोजन किया है?			16) क्या आपने विगत वर्ष में कान छिदवाया/ टेटू या एक्यूपंचर /एन्डोस्कोपी करायी है?
3) क्या आपको विगत रात्रि ठीक से नींद आयी है?			17) क्या आपने कोई इन्जेक्शन या इम्यूनोग्लोबलिन लिया है?
4) क्या आपको कभी हृदय, फेंफड़े यकृत, आमाशय या रक्त सम्बन्धी विकार तो नहीं हुआ?	11) क्या आपने पिछले 72 घंटे में निम्न औषधियों का सेवन किया है? - एंटीबायोटिक्स - एस्प्रीन, स्टीरायड		18) क्या आपने विगत छः या बारह माह में कोई शल्य चिकित्सा कराई है?
5) क्या आपको कभी कैंसर या टयूमर हुआ है?			19) क्या अपने कभी पूर्व में रक्त या रक्त उत्पाद ग्रहण किया है?
6) क्या आपको विगत 3 माह में मलेरिया हुआ है?			20) क्या आपको विगत ६ माह में चेचक/डेंगु, गलसुआ/चिकनगुनिया हुआ है?
7) क्या आपको कभी पीलिया हुआ है?	12) क्या आपने विगत दो दिनों में शराब/ नशीली वस्तु का सेवन किया है?		21) केवल स्त्रियों हेतु - क्या आप गर्भवती हैं? - विगत छः माह में गर्भपात - क्या आप स्तन पान करा रही हैं? - महावारी में अधिक रक्तस्राव - महावारी की तिथि _____
8) क्या आपको क्षय रोग या टायफाइड हुआ है?	13) क्या आप किसी निबंधित दवा या पदार्थ का सेवन करते है?		
9) क्या आप ज्वर या सर्दी से पीड़ित है?	14) क्या आपने विगत तीन माह में कोई दन्त शल्य चिकित्सा कराई है?		

रक्त दान हेतु सहमति – मैं एक यूनिट सम्पूर्ण रक्त या एफेरेसिस के लिए सहमति देता/देती हूँ। मुझे रक्तदान प्रक्रिया, उसके प्रभाव तथा विभिन्न रोगों के विन्डो पिरियड (जिसमें उसके परीक्षण नकारात्मक हो सकते है) के बारे में पूर्ण रूप से बता दिया गया है। मैं ब्लड बैंक को रक्त के परीक्षण एवं प्रयोग के लिए जैसा भी विधिसंगत हो, अधिकृत करता/करती हूँ। मुझे प्रश्न करने तथा सहमति न प्रदान करने का पूरा अवसर दिया गया। मैंने सभी प्रश्नों का ईमानदारी से उत्तर दिया है। मैं सहमत हूँ कि ब्लड डोनेशन एक स्वैच्छिक चिकित्सीय विधान है और रक्तदान करके मैं उससे संबंधित रिस्क भी स्वीकार करता/करती हूँ। मैं सहमत हूँ कि मेरे द्वारा डोनेटिड ब्लड हिपेटाइसिस बी.सी., एच.आई.वी. मलेरिया, सिफलिस के लिए स्क्रीन किया जाये, तथा ब्लड सैफ्टी के लिए आवश्यक किसी अन्य टैस्ट के लिए भी। मैं सहमत हूँ कि यह रक्त/प्लाज्मा फ्रेक्शनेशन। उससे बनने वाली दवाईयों/रिसर्च पैनल के लिए प्रयोग में लिया जा सकता है। आवश्यकता होने पर यह रक्त किसी अन्य रक्त केन्द्र को दिया जा सकता है।

क्या आप अपने द्वारा दिये गए पते पर अपने रक्त परीक्षण के परिणाम की सूचना चाहते हो? ☐ हाँ ☐ नही ☐ फोन ☐ पत्र ☐ ई-मेल

रक्तदाता के हस्ताक्षर

ब्लड बैंक के प्रयोगार्थ

चिकित्सीय परीक्षण : हीमोग्लोबिन ☐☐•☐☐ वजन कि.ग्रा. ☐☐☐ लम्बाई फीट ☐•☐☐

द्वारा _____ यंत्र नं _____

रक्त चाप ☐☐☐/☐☐ मिमि म॰ तापमान (डि.ग्री) ☐ नाड़ी गति/मिनट ☐☐

शिरा भेदन का स्थान .....

☐ स्वीकृत ☐ अस्थाई रूप से अस्वीकृत ☐ स्थाई रूप से अस्वीकृत अस्वीकृति का कारण.....

रक्तदाता प्रतिक्रिया (यदि कोई हो) 1. हीमेटोसा हाँ ☐ नहीं ☐ | 2. नौसिया हाँ ☐ नहीं ☐ | 3. उल्टी हाँ ☐ नहीं ☐
4. चक्कर हाँ ☐ नहीं ☐ | 5. वेसोवेगल हाँ ☐ नहीं ☐ | 6. सिनकोप हाँ ☐ नहीं ☐

रक्तदान पूर्ण प्रतिक्रिया रहित हाँ ☐ नहीं ☐

शिराभेदन का आरम्भ ☐☐ घंटा ☐☐ मि. शिराभेदन का समापन समय ☐☐ घंटा ☐☐ मि. रक्तसंग्रह का समय ☐☐ घंटा ☐☐ मि.

रक्तदाता के हस्ताक्षर

टेक्नीशीयन ह./नाम / कोड न. **समय** **चिकित्साधिकारी**

LIONS BLOOD CENTRE

A UNIT OF "LIONS CLUBS INTERNATIONAL DISTRICT 321-A TRUST
(Regional Blood Transfusion Centre North - West)
Recognised by : State Blood Transfusion Council (Govt. of NCT Delhi)

100% VOLUNTARY BLOOD DONATION

AK-100, SHALIMAR BAGH, DELHI-110 088
Tel. No.: 011-47122000 M : 9717897500, 9717897507, 9717897509, 9717897520 | lionsbloodbank@hotmail.com

DONOR REGISTRATION, SELECTION AND CONSENT FORM

Bag Type :		
DB 350 ☐	DB 450 ☐	QB ☐
TB 350 ☐	TB 450 ☐	IB ☐

Segment No
Lot No
DONOR ID

Camp Name

Camp Date DD MM YY

Time Hrs. Min.

PLEASE FILL THIS FORM IN CAPITAL LETTERS

Donor Name

Age Yrs Sex M F other Occupation

Date of Birth DD MM YY

Nationality ☐ Indian ☐ Others

Marital Status ☐ Unmarried ☐ Married

Father's/Husband's Name

Address

Pin Code

Mobile

Tel : (off.) with code

Resi. with code

E-mail

Your Blood Group A B AB O POS. NEG. Don't Know ☐

Predonation counselling By _____

Answer the following honestly and correctly. These are for your safety and the safety of patients who will receive your blood. This information will remain confidential. If you have any illness not covered here please tell the interviewer.

Have you donated blood earlier : ☐ Yes ☐ No If YES, date of last donation.....

Have you donated blood earlier with Lions Blood Centre ☐ Yes ☐ No If YES, date of last donation or Donor ID

.....

Have you been previously deferred, if yes, reason .....

Have you ever experienced any problem after donation ☐ Yes ☐ No

Do you want to be a Regular Voluntary Donor ☐ Yes ☐ No

If yes, how often would you like to donate : **3 Monthly** **6 Monthly** **Life Saving Ambassdor Programme**

LSAP : ON CALL DONOR FOR LIFE SAVING EMERGENCIES

Tick ✔ the Appropriate Answer

1. **Are you in Good Health Today? Do you feel well?** ☐ Yes ☐ No
2. **Did you have something to eat in last 4 hours?** ☐ Yes ☐ No
3. **Did you sleep well last night?** ☐ Yes ☐ No

P.T.O.

4. Do you suffer or have suffered from any of the following diseases?

Lung Diseases	☐ Yes	☐ No	Kidney Diseases	☐ Yes	☐ No	Ear Piercing	☐ Yes	☐ No	
Cancer / Malignant Disease	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Endoscopy	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Major Surgery	☐ Yes	☐ No	
Abnormal Bleeding Tendency	☐ Yes	☐ No	Asthma Diseases	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	
Jaundice, Hepatitis A/E	☐ Yes	☐ No	Allergic Diseases	☐ Yes	☐ No	By Pass/ Open Heart Surgery	☐ Yes	☐ No	
Jaundice, Hepatitis B/C	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No	Bone Marrow Donation	☐ Yes	☐ No	
Sexually Trans. Diseases	☐ Yes	☐ No	Typhoid	☐ Yes	☐ No				
Dog Bite/Rabies Vaccine (1 year)	☐ Yes	☐ No	Tattoo	☐ Yes	☐ No				

If you have any other illness not covered here please mention

5. Have you any reason to believe that you may be infected by either hepatitis, HIV/AIDS, and, or Sexually Transmitted Disease? ☐ Yes ☐ No

6. In last 6 months have you had history of the following?

Unexplained weight loss	☐ Yes	☐ No	Dental Extraction	☐ Yes	☐ No	Chiken Pox	☐ Yes	☐ No	2 weeks
Persistent Cough	☐ Yes	☐ No	Minor Surgery	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	
Repeated Diarrhoea	☐ Yes	☐ No	Malaria (3months)	☐ Yes	☐ No	Measles	☐ Yes	☐ No	
Swollen glands	☐ Yes	☐ No	Dengue	☐ Yes	☐ No	Inj. Tetanus Toxoid	☐ Yes	☐ No	
Continuous low grade fever	☐ Yes	☐ No	Swine Flu	☐ Yes	☐ No				

7. Are you taking or have taken any of these MEDICINES in the past 72 hours ?

Antibiotics ☐ Yes ☐ No Aspirin ☐ Yes ☐ No Alcohol ☐ Yes ☐ No

Steroid ☐ Yes ☐ No Vaccinations ☐ Yes ☐ No Any Other .....

8. For Female Donors

Are you pregnant ☐ Yes ☐ No When did you have last menstrual Period.....

Have you had an abortion in last six months ☐ Yes ☐ No Do you have a child less than one year old ☐ Yes ☐ No

9. DECLARATION AND CONSENT : • I declare that I have read and understood the information regarding voluntary blood donation and have answered all the questions honestly and correctly. • I understand that blood donation is a medical procedure and by donating blood voluntarily I accept the risk associated with. • I give my consent to screen my donated blood for Hepatitis B, Hepatitis C, HIV, Malaria & Venereal Disease in addition to any other screening test required to ensure blood safety and I would like to be informed about any abnormal test result by Letter / Phone / SMS / e-mail: • I agree that the blood donated by me be used for the benefit of patients, in any manner as decided by the Blood Centre i e for making blood components and / or for preparation of panels, scientific research and / or for indigenous manufacturing and / or for plasma fractionation and derivation of essential plasma derived medicines. Also, the Blood / Component can be transferred to other Blood Centres.

I affirm that the staff on duty provided me the opportunity to ask question and to refuse consent.

Signature of Donor

FOR BLOOD BANK USE ONLY

Physical Examination : Hb (gm%) ☐☐ • ☐☐ **Weight (Kg.)** ☐☐☐ **(FT) Height** ☐ • ☐

Hb Done by ..... **Equipment no.** ☐

Blood Pressure (mmHg) ☐☐☐ / ☐☐☐ **Temperature (Deg.)** ☐ **Pulse / min** ☐☐

Condition of Phlebotomy site..... **Accept** ☐ **Temporary Defer** ☐ **Permanent Defer** ☐

Cause of Deferal.....

Donor Reaction (if any) :

Haematoma	☐	Mild Vasovagal	☐
Nausea	☐	Hyperventilation	☐
Vomitting	☐	Syncope	☐
Dizziness	☐	Convulsion	☐

Phlebotomy :

Start Time	
End Time	
Duration	
BCM No.	

Blood Collection

Completed Uneventful	yes ☐ No ☐
Less Collection	yes ☐ Wt gm ☐ No ☐

Action Taken.....

Name & Signature of Technician / Phlebotomist **Signature of Donor**..... **Signature of Medical Officer**

Time .....

DC/09/2024

LIONS BLOOD CENTRE

LBC/DOC/IH/001

(Regional Blood Transfusion Centre (North - West)
Recognized by : State Blood Transfusion Council, Govt. of NCT of DELHI, Licence No. 1899

100% VOLUNTARY BLOOD DONATION

NABH ACCREDITED

AK-100, Shalimar Bagh, Delhi-110 088
Tel. No.: 011-47122000 (100 Lines)
Mobile No. 9717897500, 9717897520
E-mail : lionsbloodbank@hotmail.com

FOR BLOOD CENTRE USE ONLY

RID

FOR BLOOD CENTRE USE ONLY

Receipt No.

BLOOD REQUISITION FORM

Patient's Name .....

Age / Sex.....Blood Group.....

Father's/Husband's Name.....

C.R. No..... Date of Admission.....

Hospital Name.....

Ward No. .....Bed No.....

Clinical Diagnosis.....

Doctor Incharge.....

Date & Time of Request Sent.....

Indication for transfusion .....

Hb:.....TLC ..... Platelet Count.....

Previous Transfusion : Yes..... No.....

if Yes, Date of Last Transfusion .....

Any Adverse Effect.....Yes.....No.....

History of Drug Intake.....

In Female Patients H/o .....

Pregnancy Gravida Para

Still birth HDFN Miscarriage

NUMBERS OF UNITS REQUIRED : NAT TESTED

Blood Requisition: Routine / Urgent / Immediate
(Please tick the appropriate)

PRBC:- Leucoreduced PRBC:- FFP:- Platelet Concentrate:- Platelet Apheresis:-

Certified that I have personally collected the blood sample of the patient after proper identification and signed the label on sample tube/vacutainer *(2ml blood in plain and 5ml in EDTA vial. Sample will not be accepted in syringes.)*, and that informed consent for blood transfusion has been taken from the patient/relative and kept in the patient's case record.

Sample Collected at (Date & Time).....

Name & Sign. of Phlebotomist

Signature and Stamp of requesting Doctor

INSTRUCTIONS FOR STRICT COMPLIANCE

- Requisitions are accepted round the clock
- Sample label on tube/vacutainer must be signed by phlebotomist
- Unlabeled, incorrect, Incomplete or illegible labelled specimen or those with discrepancy to the requisition form will not be accepted
- For New born baby up to 6 months of age, 2ml blood is required along with mother's blood sample
- Make sure that blood or blood components are arranged before any major surgery
- Blood components once issued will not be taken back by the blood centre
- In case of non availability of specific group alternative group can be considered
- Time taken for complete Compatibility Testing in normal circumstances is approx. 1 hour and 30 minutes

Indications for Component Usage - Overleaf

LIONS INITIATIVE FOR SAFEST POSSIBLE BLOOD

FOR BLOOD CENTRE LAB. USE (IMMUNOHAEMATOLOGY LAB)

Sample Received by:-.....Date / Time.....

Patient's Blood Group (Slide Method)..... Done by.....

Tube / CAT Method	Anti-A	Anti-B	Anti-AB	Anti-D_1	Anti-D_2	A1 Cell	B Cell	O Cell	Interpretation	Tested By	Date/Time

ANTIBODY SCREENING

O_1 Cells	O_2 Cells	O_3 Cells	Auto Control	DAT

ABO X-Match

S. No.	Unit No.	Segment No.	Blood Component	Repeat Blood Group	Saline / Column Agglutination Test	Interpretation Compatible : Yes Incompatible : No
1.						
2.						
3.						
4.						
5.						

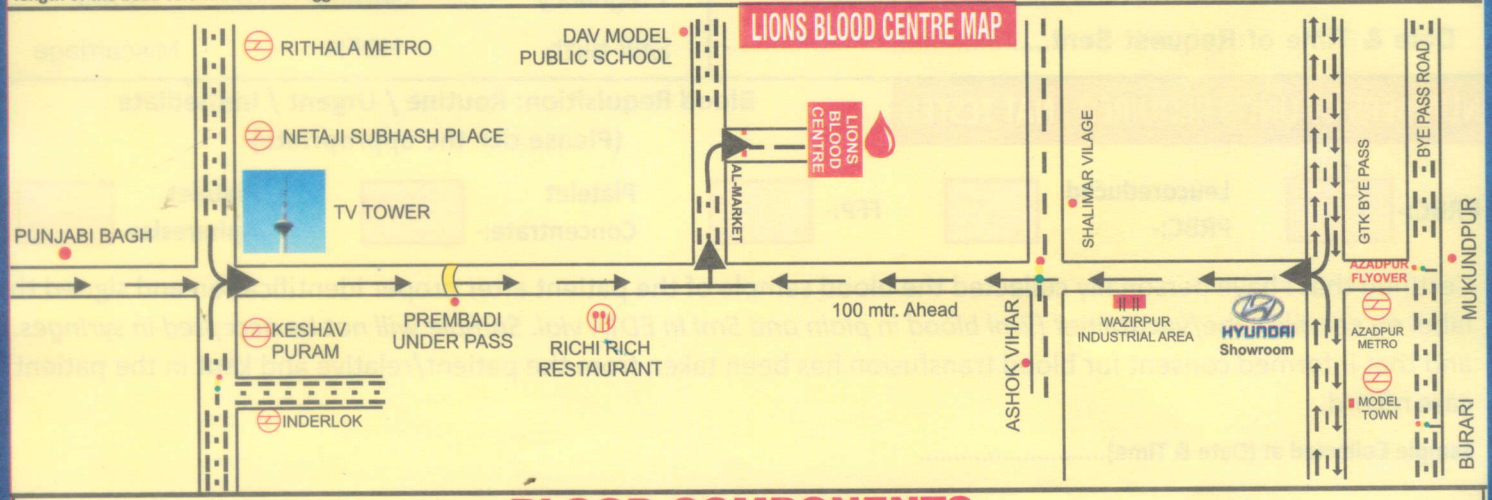
Cross Match By : Name & Signature..... Date..... Time.....

Counter Checked by.....

Issued By..... Blood Received By.....Date.....Time.....

4+ Agglutinated cells form a band at the top of the bead column. 3+ Most agglutinated cells remain in the upper half of the bead column. 2+ Agglutinated cells observed throughout the length of the bead column. 1+ Most agglutinated cells remains in the lower half of the bead column, 0 A button of non agglutinated cells at the bottom of the bead column.

LIONS BLOOD CENTRE MAP



BLOOD COMPONENTS

COMPONENT	INDICATION	DOSAGE	SELECTING BLOOD GROUP
RED BLOOD CELLS (PRBC) - CPDA 180-240 ml - In additive solution 330-370 ml - Leucodepleted / Leucopoor / Leucoreduced	• Active bleeding with or without hypovolemic shock • Synptomatic chronic anaemia unresponsive to conservative therapy • Hb<7gm/dl • Hb<7gm/dl in patient with cardiac Pulmonary or neurogenic disease. • Clinical oxygenation problem at any Hb level • Blood loss> 15% of Blood volume in adults, >10% of Blood volume in children. • Neonatal exchange transfusion.	One unit PRBC in an adult, 8 ml/kg paediatric dose will increase haematocrit by approximately 3% and Hb by 1 gm/dl	- ABO Type specific compatible - In Absence of ABO type specific blood "O" PRBC can be transfused - Rh Negative recipient shall receive Rh 'O' Negative PRC - Rh Positive recipient can receive either Rh (O) positive or negative PRBC - If clinically significant unexpected antibodies are detected in recipient PRBC lacking the corresponding antigen and compatible are selected.
RANDOM DONOR PLATELETS - (RDP) 50-70 ml - (BC-PLC) 70-90 ml	• Platelet count <10,000/-ml prophylactically in a patient with failure of platelet production • Platelet count <20,000/µl and signs of haemorrhagic diathesis (petechie, mucosal bleeding) • Platelet count <50,000/µl in a patient with - Active haemorrhage / invasive procedures / Platelet dysfunction	1 unit RDP increase platelet count by 5000-7000 /µl in stable adults	- ABO and Rh type specific preferable - In case of shortage, any ABO/Rh can be used provided there is no visual red cell contamination.
SINGLE DONOR PLATELETS - (SDP) > 200 ml	• 1 Unir SDP is = approx. 6 RDP's. • Reduces multiple donor exposure	1 unit SDP increases platelet counts by 25000-35000 /µl in stable adult	- ABO & Rh type specific
FRESH FROZEN PLASMA - (FFP) 150-220 ml	• Massive blood transfusion. • Coagulation factor deficiency (<25%) • Exchange Transfusion. Liver Transplant.	10-15 ml/KG increases factor levels by 20-30	- ABO Type Specific compatible with recipients red cells

LIONS BLOOD CENTRE

LBB/DOC/NUR/001.1/Rev-2

A UNIT OF "LIONS CLUBS INTERNATIONAL DISTRICT 321-A TRUST

100% VOLUNTARY BLOOD DONATION

AK-100, SHALIMAR BAGH, DELHI-110 088
Tel. No.: 47122000 Mob. : 9717897500, 971789752020
Email : lionsbloodbank@hotmail.com

APHERESIS DONOR REGISTRATION, SELECTION AND CONSENT FORM

DONOR ID

Platelets ☐

Plasma ☐

Date DD MM YY

Time Hrs. Min.

PLEASE FILL THIS FORM IN CAPITAL LETTERS

Donor Name

Age Yrs Sex M F other Occupation

Date of Birth DD MM YY Nationality Indian Others Marital Status Unmarried Married

Father's/Husband's Name

Address

Pin Code Mobile

Tel : (off.) with code Resi. with code

E-mail

Your Blood Group A B AB O POS. NEG. Don't Know

Predonation counselling By _____

Answer the following honestly and correctly. These are for your safety and the safety of patients who will receive your blood. This information will remain confidential. If you have any illness not covered here please tell the interviewer.

Have you donated blood Centre : Yes No If YES, date of last donation.....

Have you donated blood earlier with Lions Blood Bank: Yes No If YES, date of last donation or Donor ID

.....

Have you been previously deferred, if yes, reason .....

Have you ever experienced any problem after donation Yes No

Do you want to be a Regular Voluntary Blood Donor Yes No

If yes, how often would you like to donate : 3 Monthly 6 Monthly

Life Saving Ambassdor Programme

LSAP : ON CALL DONOR FOR LIFE SAVING EMERGENCIES

Tick ✔ the Appropriate Answer

1. **Are you in Good Health Today? Do you feel well ?** Yes No
2. **Do you have something to eat in last 4 hours** Yes No
3. **Did you sleep well last night** Yes No

P.T.O.

4. Do you suffer or have suffered from any of the following diseases?

Lung Diseases	☐ Yes	☐ No	Kidney Diseases	☐ Yes	☐ No	Ear Piercing	☐ Yes	☐ No
Cancer / Malignant Disease	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Endoscopy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Major Surgery	☐ Yes	☐ No
Abnormal Bleeding Tendency	☐ Yes	☐ No	Asthma Diseases	☐ Yes	☐ No	Bone Marrow Donation	☐ Yes	☐ No
Jaundice, Hepatitis A/E	☐ Yes	☐ No	Allergic Diseases	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Jaundice, Hepatitis B/C	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No	By Pass/Open Heart Surgery	☐ Yes	☐ No
Sexually Trans. Diseases	☐ Yes	☐ No	Typhoid	☐ Yes	☐ No	If you have any other illness not covered here please mention		
Dog Bite/Rabies Vaccine (1 year)	☐ Yes	☐ No	Tattoo	☐ Yes	☐ No			

5. Have you any reason to believe that you may be infected by either hepatitis, HIV/AIDS, and, or Sexually Transmitted Disease? ☐ Yes ☐ No

6. In last 6 months have you had history of the following?

Unexplained weight loss	☐ Yes	☐ No	Dental Extraction	☐ Yes	☐ No	Chiken Pox	☐ Yes	☐ No	2 weeks
Persistent Cough	☐ Yes	☐ No	Minor Surgery	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	
Repeated Diarrhoea	☐ Yes	☐ No	Malaria (3months)	☐ Yes	☐ No	Measles	☐ Yes	☐ No	
Swollen glands	☐ Yes	☐ No	Dengue	☐ Yes	☐ No	Inj. Tetanus Toxoid	☐ Yes	☐ No	
Continuous low grade fever	☐ Yes	☐ No	Swine Flu	☐ Yes	☐ No				

7. Are you taking or have taken any of these MEDICINES in the past 72 hours ?

Antibiotics	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Alcohol	☐ Yes	☐ No
Steroid	☐ Yes	☐ No	Vaccinations	☐ Yes	☐ No	Any Other		

8. For Female Donors

Are you pregnant ☐ Yes ☐ No When did you have last menstrual Period.....

Have you had an abortion in last six months ☐ Yes ☐ No Do you have a child less than one year old ☐ Yes ☐ No

9. DECLARATION AND CONSENT : • I declare that I have read and understood the information regarding voluntary blood donation and have answered all the questions honestly and correctly. • I understand that blood donation is a medical procedure and by donating blood voluntarily I accept the risk associated with. • I give my consent to screen my donated blood for Hepatitis B, Hepatitis C, HIV, Malaria Parasite & Venereal disease in addition to any other screening test required to ensure blood safety and I would like to be informed about any abnormal test result by Letter / Phone / SMS / e-mail: • I agree that the blood donated by me be used for the benefit of patients, in any manner as decided by the Blood Centre i e for making blood components and / or for preparation of panels, scientific research and / or for indigenous manufacturing and / or for plasma fractionation and derivation of essential plasma derived medicines. Also the Blood / Component can be transferred to other Blood Centres.

I affirm that the staff on duty provided me the opportunity to ask question and refuse consent.

Signature of Donor

FOR BLOOD BANK USE ONLY

Physical Examination : Hb (gm%) ☐☐•☐☐ **Weight (Kg.)** ☐☐☐ **Height** ☐•☐

Hb Done by ..... **Equipment no.** ☐☐☐ **Temperature (Deg.)** ☐ F/C **Pulse / min** ☐☐

Blood Pressure (mmHg) ☐☐☐ / ☐☐☐

Condition of Phlebotomy site..... **Accept** ☐ **Defer** ☐

Cause of Deferal..... **Temporary Defer** ☐ **Permanent Defer** ☐

Donor Reaction (if any) :

Haematoma	☐	Mild Vasovagal	☐
Nausea	☐	Hyperventilation	☐
Vomitting	☐	Syncope	☐
Dizziness	☐	Convulsion	☐

Phlebotomy :

Start Time	
End Time	
Duration	
BCM No.	

Blood Collection

Completed Uneventful	yes ☐ No ☐
Less Collection	yes ☐ Wt gm No ☐

Action Taken.....

Name & Signature of Technician / Phlebotomist **Signature of Donor**..... **Signature of Medical Officer**

Time .....

LIONS BLOOD CENTRE

(Regional Blood Transfusion Centre (North - West), SBTC, Licence No. 1899)

100% VOLUNTARY BLOOD DONATION

AK-100, SHALIMAR BAGH, DELHI - 110 088
PHONE. : 47122000 Mob. : 9717897500, 20
E-mail : lionsbloodbank@hotmail.com

TRANSFUSION REACTION REPORT

Patient's Name ..... **Recipt No**.....

Hospital..... **Adm./CR No**.....

Diagnosis..... **Indication of transfusion**.....

Blood Component : PRBC☐ FFP☐ PLC☐ Blood Bag No.....**Blood Group** .....

Bed Side clerical Checks

Did information on Blood Bag label, patient records and compatibility report mach ? **Yes**☐ **No**☐

Transfusion Details

- Other Transfusion in last 24 hrs.....
- I-V Solutions used.....
- Was medication added to the unit or IV tubing?
- Premedication given **Yes**☐ **No**☐ (mention drugs).....
- Has the Patient been running temperature in last 24 hours
- Maximum temperature in 24 hours

Signs& symptoms Tick ✓ Those Which apply

☐ Blood Transfusion unvenentful

☐ Urticaria
☐ Itching
☐ Nausea
☐ Vomiting

☐ Increased Pulse
☐ Chills
☐ Elevated Temp>1°C
☐ Flushing
☐ Muscle aching
☐ Back Pain
☐ Pain at infusion site

☐ Hypotension
☐ Dysponea
☐ Shock

☐ Dark of red Urine
☐ Decreased Urine output
☐ Petechiae
☐ Failure to clot
☐ Jaundice

Other .....

•[A temperature rise more 1°c is a febrile response]

Medical Officer's Name & Sign.

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BED SIDE VERIFICATION AND TRANSFUSION RECORD

Patient's Name ..... **Age/Sex.** ..... **Blood Group**.....

Hospital ..... **Hospital CR No**.....

Blood Component ..... **Blood Bag No**.....**Blood Group**.....

Bed Side Verification by Medical Officer before starting transfusion: **I Verify that-**

1. The recipients name and hospital registration number mentioned on the blood bag and compatibility report match.
2. The donor unit number and blood component name on the bag label matches with the information on Compatibility Report .
3. The Donor and recipients blood group are compatible.
4. I have checked blood bag for expiry, Leakage, discoloration or clot and no abnormality was detected.

Medical officer's Name & sign. Date & Time

TRANSFUSION RECORD

		Time	Temperature	Blood Pressure	Pulse	Resp. Rate	Sign.
Pre Transfusion							
At The Start Of Transfusion							
During Transfusion	15 Min.						
	30 Min.						
	1 ½ hr						
	2 hr						
	2 ½ hr						
	3 hr						
	3 ½ hr						
On Completion of Transfusion							
Post Transfusion 1 hr							

No Reaction and Transfusion Completed Uneventful ☐

Medical Officer's Name & Sign.
Date & Time

Haemovigilence

Properly Fill & Return this form to Lions Blood Centre after Completion of Transfusion.
You can scan mail this form to LBC at **Haemovigilence@lionsbloodbankdelhi.org** as per requirement of NABH Accreditation guidelines for Haemovigilence.

INSTRUCTIONS

1. Transfuse blood components immediately after verification.
2. Transfusion must be given by disposable set with filter.
3. Transfusion of red cell should begin within 30 minutes of taking out of refrigerator and shall not longer then 4 hours.
4. No other intravenous fluid except 0.9% sodium chloride should be administrated with blood component.
5. In case of transfusion reaction, stop the transfusion immediately and verify identification of unit and patient. Complete the reaction report form and send the blood bag along with patient's blood sample in plain and EDTA vials taken form a vein other the transfusion line to the Blood Centre.

TRANSFUSION REACTION REPORT FORM OVERLEAF