

# Thank you very much for giving blood

## Blood, a possible channel for the transmission of infectious diseases

Blood can be a **vehicle for the transmission of pathogens** (bacteria, viruses and parasites) responsible for many diseases such as hepatitis, AIDS, Chagas' disease and syphilis.

To prevent transmission, blood banks perform very sensitive **analyses** for detecting pathogens. They are, however, not always detected in these tests. It is therefore **VERY IMPORTANT for people who may be carriers of any of these pathogens NOT TO GIVE BLOOD.**

### YOU MUST NOT DONATE BLOOD if:

- You are or believe you may be a carrier of the **human immunodeficiency virus (HIV)** or **AIDS virus**.
- You are or believe you may be a carrier of any **hepatitis virus (B or C)**.
- You have injected **drugs** (heroin, bodybuilding hormones, etc.) at any time in your life, even if was only once and a long time ago.
- You have ever accepted money, drugs or any other type of payment in exchange for **sexual intercourse**.
- You have had **sexual relations** in the last 4 months with: **one or more casual partners**, different partners, someone who changes partners **frequently**, someone **who may have injected intravenous drugs**, someone who works or has worked as a prostitute.
- You have had sexual relations in the last year with someone who has the **AIDS virus (HIV)** or the **HTLV-I, II virus**.

Giving blood is **not an appropriate method with which to determine your state of health or to have a blood test done**. If that is what you require, you should:

- Consult your family doctor.
- Call the AIDS information helpline: **900 212 222**

### BLOOD DONATION AND BIOBANK

#### I hereby give my consent to:

1. Having blood taken from me for treating the sick.
2. In the event of not being possible to use this for said purpose, the blood and/or its components being kept anonymously at the Biobank recognised by the Banc de Sang i Teixits (Blood and Tissue Bank), for these to be applied in authorised biomedical research work intended for the progress of knowledge on the prevention, diagnosis, prognosis and/or treatment of diseases, as well as for improving biomedical control systems.
3. In exceptional circumstances, if they are not used for the above purposes, the blood and/or its components may be used for teaching work and/or for preparing diagnosis and therapy items, by the Banc de Sang i Teixits or other organisations or bodies.

#### I hereby declare that:

1. I have received understandable complementary information about:
  - The nature of blood and its components, the mechanisms of donation and the benefits stemming from it.
  - The reasons justifying the need to be examined, the causes for exclusion and rejection of the blood obtained and the importance of consent.
  - The possibility of suspending or excluding the donation at any time, and of revoking consent to keep the product or apply this to research work, where applicable.
  - The commitment that the traceability of the donation will be guaranteed and that I will be given any information obtained from the analyses that might be important for my health.
  - The importance of my informing of any illness after the donation which might affect the use of the blood.
2. I have understood the information and any questions that I might have asked have been satisfactorily answered.
3. Everything I have declared in the questionnaire filled in by me is true and correct.

4. I am aware that giving blood is a voluntary and altruistic act and that I will consequently not be given any compensation, either economic or of any other kind, nor in the event of the research authorised with the product of the donation possibly generating any profit.

### PROCESSING OF PERSONAL DATA

#### I agree that:

1. The Blood and Tissue Bank (BST) may use my personal data to send me the information that it deems of interest with regard to the donation of blood.
2. The BST may provide solely my essential data to organisations that undertake to send emails, mailings, text messages or make calls with the sole purpose of informing me or inviting me to donation campaigns. These third parties agree to respect the BST policy of confidentiality and of protection of the interested parties' personal data.

#### I declare that:

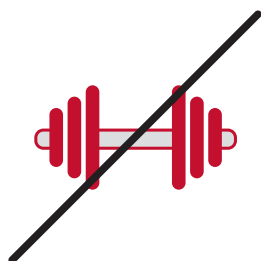
1. I have been informed, in accordance with the law, that my personal data will be incorporated, as required, on the Register of Blood Donors of Catalonia, which is managed by the BST and for which the Directorate-General for Health Planning and Regulation of the Catalan Ministry of Health is responsible, to the necessary end of properly managing the process of donation and of applying blood-derived components.
2. I have been guaranteed that the data will be kept confidentially and subject to strict security measures, without prejudice to the exceptions established by law.
3. I understand that, whenever I wish I may contact the data controller (BST, pg. Taulat, 116. 08005 Barcelona. Tel. 93 557 35 00) in order to exercise my rights of access, rectification, cancellation, opposition, erasure, restriction of treatment and portability of the data, in accordance with the terms established in applicable legislation.

You may consult the data protection policy at [bancsang.net](http://bancsang.net) or request it at donation sites.

## Recommendations after having given blood



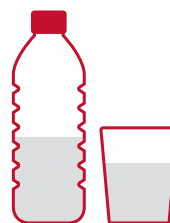
Do not remove the plaster for at least **2 hours**



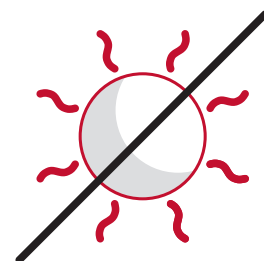
Do not do strenuous physical exercise for **24 hours** particularly with the arm from which blood was taken



Do not drink alcohol or smoke for **2 hours**



Drink plenty of liquid in the subsequent **24-48 hours**



Avoid very hot places. Well-ventilated, cool zones are better

### We also recommend that you should:

- Resume normal activity as soon as possible. Walk rather than sit still in a chair.
- Include salty ingredients in your diet for 24-48 hours.
- If the injection site bleeds when you remove the plaster, press the wound for 3-5 minutes.

### If you feel faint at all:

- Lie down and ask people around you for help.
- Do not try to remain upright.
- Once lying down, raise your legs to stimulate circulation.
- Cross your ankles and every 5 seconds contract and relax the muscles in your legs and backside.
- The feeling of faintness will soon disappear.

If you have to do a blood test in the coming days, tell the doctor that you have given blood so he or she may interpret the results of your test properly.

### Help us prevent transfusion problems

If in the days after donating you suffer from fever, malaise or a severe health problem, please get in touch with the Banc de Sang.

If you should feel any discomfort or would like to offer us any suggestions, please contact any of our **permanent donation centres** or our **Donor Service Centre (93 557 35 66)** or write to us at [atenciodonant@bst.cat](mailto:atenciodonant@bst.cat)

For further information:

**93 557 35 66**  
**donarsang.gencat.cat**



BANC DE SANG  
I TEIXITS

*Moltes  
gràcies*

Donation number

**Please write in capital letters**

Name \_\_\_\_\_  
 Surname(s) \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 National ID No. \_\_\_\_\_  
 Address \_\_\_\_\_  
 Postcode \_\_\_\_\_  
 Town \_\_\_\_\_  
 Landline \_\_\_\_\_ Mobile \_\_\_\_\_  
 email \_\_\_\_\_  
 Sex  Male  Female

Preferred language  Catalan  Spanish

**Basic conditions for donation**

**YES NO**

Are you 18 years of age or over and weigh at least 50 kilos? \_\_\_\_\_

Are you in good health? \_\_\_\_\_

If you are a woman, are you pregnant or have you been so in the past 6 months? \_\_\_\_\_

**Country of birth**

Of the donor \_\_\_\_\_

Of the mother \_\_\_\_\_

Date of last trip to your country of birth \_\_\_\_\_

**Please complete the questionnaire on the back before signing**

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Donor's name and surname(s)

Signed

**To be completed by the interviewer**

Donor number \_\_\_\_\_  
 Date of blood draw \_\_\_\_\_  
 Collection code \_\_\_\_\_ Donation type \_\_\_\_\_  
 Weight \_\_\_\_\_ Hb \_\_\_\_\_ BP \_\_\_\_\_  
 Pulse \_\_\_\_\_ Bag type \_\_\_\_\_  
 CIP (CatSalut code card) \_\_\_\_\_  
 Nurse in charge \_\_\_\_\_  
 Observations \_\_\_\_\_

I consider the donor is:

- NOT SUITABLE** for donation (the donor has understood the reasons)
- SUITABLE with UNIVERSAL** blood test
- |              |                              |                             |
|--------------|------------------------------|-----------------------------|
| CHAGAS test  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| MALARIA test | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| WNV test     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Name and surname(s) of the interviewer

Signed

Understanding of the informative brochure	YES NO	In the past 12 months	YES NO
Has the Blood Bank issued you with understandable written information on blood donation? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you travelled outside Spain? _____	<input type="checkbox"/> <input type="checkbox"/>
<i>(if you require clarification, please ask the attending professionals any question that you feel is relevant)</i>		Where? _____	
		Date of return _____	
<b>Proceed with caution in the next 12 hours</b>		<b>At any time in your life</b>	
Do you have to perform any dangerous work or sports activity (deep sea diving, climbing, etc.) or drive a public transport vehicle? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you lived outside Spain? _____	<input type="checkbox"/> <input type="checkbox"/>
<b>Are you on a waiting list?</b>		Where? _____	
Are you currently on a waiting list for a medical appointment or examination? _____	<input type="checkbox"/> <input type="checkbox"/>	Length of stay _____	
<b>Medication</b>		Date of return _____	
Are you taking or have you taken any pharmaceutical drug in the last few days? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you ever travelled to America? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you ever taken medication for a prostate problem or alopecia (Finasteride, Avidart, Duagen, Proscar, Propecia, Finasteride, Eucoprost or Ativol)? _____	<input type="checkbox"/> <input type="checkbox"/>	Where? _____	
Have you ever taken medication for acne? (Neotigason, Roacutan, Tigason or Isotrex) _____	<input type="checkbox"/> <input type="checkbox"/>	Date of return _____	
<b>In the past 2 weeks</b>		Have you spent over a year –counting all stays– in the United Kingdom (England, Wales, Scotland, Northern Ireland, Channel Islands, Isle of Man) in the period from 1980 to 1996? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you suffered from fever with a headache and generally felt unwell? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you been refused as a donor? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you been to the dentist? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you had a serious disease that required periodic medical supervision? _____	<input type="checkbox"/> <input type="checkbox"/>
<b>In the past month</b>		Have you had hepatitis, jaundice or liver problems? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you been in contact with anyone with a contagious infectious disease? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you suffered from any serious infectious disease such as Chagas disease, leishmaniasis, infectious mononucleosis, tuberculosis, syphilis or gonorrhoea? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you travelled outside Catalonia? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you had or think you may have had malaria? _____	<input type="checkbox"/> <input type="checkbox"/>
Where? <i>(Provinces of Spain or country)</i> _____		Date of end of symptoms _____	
<b>In the past 2 months</b>		Have you had any serious disease affecting the lungs, brain, kidneys, thyroid, digestive system or any other area? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you been vaccinated for anything? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you had heart or blood pressure problems? _____	<input type="checkbox"/> <input type="checkbox"/>
<b>In the past 4 months</b>		Have you suffered from repeated epileptic seizures, convulsions, fainting or passing out? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you visited a doctor or have you been admitted to hospital? _____	<input type="checkbox"/> <input type="checkbox"/>	Do you suffer from insulin-dependent diabetes? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you had an endoscopy: colonoscopy, gastroscopy, rectoscopy or similar procedure? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you had cancer of any kind? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you been treated with acupuncture or have you had a piercing made with non-disposable material? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you had any serious allergy-related disease or reaction? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you had a tattoo? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you had any haemorrhagic problem or any blood disease such as anaemia or an elevated red blood cell count? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you come into contact with another person's blood as a result of an accidental jab or spattering? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you ever received a blood or a clotting factor transfusion? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you been living or had close contact with anyone with hepatitis, jaundice or who is a hepatitis virus carrier? _____	<input type="checkbox"/> <input type="checkbox"/>	Were you treated with human growth hormone (prior to 1987)? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you had a surgical operation? _____	<input type="checkbox"/> <input type="checkbox"/>	Have you received any organ or tissue transplant (dura mater, cornea, other, etc.)? _____	<input type="checkbox"/> <input type="checkbox"/>
		Have you or any of your family suffered from spongiform encephalopathy (Creutzfeldt-Jakob disease)? _____	<input type="checkbox"/> <input type="checkbox"/>
		Have you had or are you infected with the human T-lymphotropic virus (HTLV-I/II)? _____	<input type="checkbox"/> <input type="checkbox"/>