SEROCONVERT DONOR NOTIFICATION FORM

IMPORTANT INFORMATION

PART 1

1. Every case of seroconverted donor shall be managed, investigated and documented accordingly.
2. Please complete Part 1 of this form and send a copy within ONE (1) month following donor counselling to the National Haemovigilance Coordinating Centre, National Blood Centre.
3. Completed original form shall be retained at the respective blood centre.

DONOR DETAILS

Name :	IC / Passport No :
Gender : Male ☐ Female ☐	Barcode :
Date of donation :	Number of previous donations :
Reported by :	Designation :
Collection centre :	Date of reporting :

1. Infectious markers implicated

☐HIV ☐HBV ☐HCV ☐Syphilis ☐Others (please specify) :_____

a. Screening (Specify method) :_____
b. Confirmation (Specify method) :_____
c. Date of confirmation (Seroconversion) :_____

2. Risk Factors

☐ High Risk Sexual Behaviour (Specify) :_____
☐ Body piercing / Tattoo/ Acupuncture (Please circle the appropriate one)
☐ History of blood transfusion (Date & Hospital involved) :_____
☐ Intravenous drug use
☐Others (please specify) :_____

IMPORTANT INFORMATION

PART 2

1. Please fill up the following for the last negative donation and donation(s) in the six (6) months period prior to the last negative donation.
2. Upon completion of Part 2, please resend the complete form to National Haemovigilance Coordinating Centre, National Blood Centre.
3. Completed original form shall be retained at the respective blood centre.

PREVIOUS DONATION RECORDS

Barcode NO: _____ **Date (DD/MM/YY) _____/_____/_____**

Donation Centre/ Hospital: _____

Type of Product:	Whole blood	Packed cells	FFP	Platelet	Cryoppt/sup	Others (……..)
Date Issued:						
Issued to Hospital/ward:						
Patient's name:						
Patient ID:						
Ward :						
Patients current status(dead/ alive/ result status) :						
Patient's Diagnosis :						

Barcode NO: _____ **Date (DD/MM/YY) _____/_____/_____**

Donation Centre/ Hospital: _____

Type of Product:	Whole blood	Packed cells	FFP	Platelet	Cryoppt/sup	Others (……..)
Date Issued:						
Issued to Hospital/ward:						
Patient's name:						
Patient ID:						
Ward :						
Patients current status(dead/ alive/ result status) :						
Patient's Diagnosis :						

*additional pages to be filled if necessary