



UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

HPC Donor Declaration and Consent

PART A: Blood Donation Statement to be completed by the Donor

The following Statement and Declaration is required by Law (from ARCBS Donor Declaration Statement).

ALL DONORS must be assessed for infectious disease risk. Your blood will be tested for the presence of Hepatitis B and C, HIV (the AIDS virus), HTLV and syphilis. Should your blood test positive for any of these conditions or show an abnormal result you will be informed. Answer each question on the form as honestly as you can and to the best of your knowledge. It is important to answer all questions.

Please respond by placing a **cross or a tick** in the relevant box. **DO NOT CIRCLE.**

To the best of your knowledge have you:

1. In the last 12 months, had an illness with swollen glands and a rash, with or without a fever? YES NO
2. Ever thought you could be infected with HIV or have AIDS? YES NO
3. Ever "used drugs" by injection or been injected, even once, with drugs not prescribed by a doctor or dentist? YES NO
4. Ever had treatment with clotting factors such as Factor VIII or Factor IX? YES NO
5. Ever had a test which showed you had hepatitis B, hepatitis C, HIV or HTLV? YES NO
6. In the last 12 months engaged in sexual activity with someone you might think would answer "yes" to any of questions (1-5)? YES NO
7. In the last 12 months engaged in sexual activity with a new partner who currently lives or has previously lived overseas? YES NO

Within the last 12 months have you:

8. Had male to male sex? YES NO
9. Had sexual activity with a male who you think might be bisexual? YES NO
10. Been a male or female sex worker (e.g. received payment for sex in money, gifts or drugs)? YES NO
11. Engaged in sexual activity with a male or female sex worker? YES NO
12. Been injured with a used needle (needlestick)? YES NO
13. Had a blood/body fluid splash to eyes, mouth, nose or to broken skin? YES NO
14. Had a tattoo (including cosmetic tattooing), body and/or ear piercing, electrolysis or acupuncture? YES NO
15. Been imprisoned in a prison or lock-up? YES NO
16. Had a blood transfusion? YES NO
17. Had (yellow) jaundice or hepatitis or been in contact with someone who has? YES NO

Thank you for answering these questions. If you are uncertain about any of your answers, please discuss them with your Doctor.

WE WOULD LIKE YOU TO SIGN THIS DECLARATION IN THE PRESENCE OF YOUR DOCTOR.

DONOR DECLARATION

- I declare that I have understood the information on the form and answered the questions in the statement to the best of my knowledge.

Donor's Signature: _____ Doctor's Signature: _____

Date: _____ Date: _____



HPC Donor Declaration and Consent MR 639/A

PART B: Consent of Parent(s) / Guardian or Donor older than eighteen years of age for Storage and Disposal of HPC

We / I _____, being the **parent (s)/ guardian of** _____ / **donor** consent to having **their / my** Haemopoietic Progenitor Cells (HPC) processed, cryopreserved and stored by The Cell Therapy and Flow Cytometry Laboratory of Laboratory Services at The Royal Children's Hospital and that details of the donation be reported to the relevant Bone Marrow Transplant Registries, ie; Center for International Blood and Marrow Transplant Research(CIBMTR)& Australasian Bone Marrow Transplant Recipient Registry(ABMTRR). **We / I** understand that:

Directed Donation	Autologous Donation
<ul style="list-style-type: none"> The donated stored HPC are for the purpose of transplantation for an identified recipient _____ (name). The HPC will remain in storage until required or as directed by the recipient's Transplant Physician. In the majority of cases all the stored HPC will be infused into the identified recipient. In some circumstances, the stored HPC are not required by the identified recipient. This is only confirmed by the recipient's Transplant Physician. 	<ul style="list-style-type: none"> These HPC are for transplantation in _____'s /my treatment. We / I may request transfer of the stored HPC to an alternative facility for transplantation. Responsibility for and cost of transfer will be discussed before transfer. We / I may have a change in decision of storage of the HPC, we / I will inform my Transplant Physician of the change in preference. All possible care will be taken to ensure successful processing and storage, however unforeseen circumstances may occur which can affect the HPC. If the stored HPC are not used for transplantation within 5years, our / my Transplant Physician will be required to provide justification for continued storage.
<p>Dr _____ has explained to us / me that there may be circumstances where the stored HPC are not required for transplantation. These situations may include:</p>	
<ul style="list-style-type: none"> The identified recipient is no longer a candidate for transplantation. This is only confirmed by the recipient's Transplant Physician. 	<ul style="list-style-type: none"> No longer a candidate for transplantation as confirmed by the Transplant Physician. Insufficient stored HPC for transplantation as confirmed by my Transplant Physician.
<p>Please respond by placing a cross or a tick in the relevant box. DO NOT CIRCLE.</p> <p>In the event of any of these situations we / I consent to:</p> <p><input type="checkbox"/> Stored HPC that are not required may be kept and used for ethically approved research, education and laboratory quality procedures.</p> <p><input type="checkbox"/> Stored HPC that are not required may be disposed of in accordance with hospital policy.</p>	

Signed _____ Signed _____

Date _____ Date _____

PART C: Declaration by Doctor for Storage and Disposal of HPC.

I have explained to the above named **parent(s) / guardian / donor** the conditions of storage and disposal of HPC. In my opinion **they have / he / she has** understood this explanation and **have / has** signed in my presence.

Signed _____

If interpreter service used:

Date _____

Name of interpreter _____