Mahatma Gandhi Medical College & Hospital
MAHATMA GANDHI UNIVERSITY OF MEDICAL SCIENCES & TECHNOLOGY, JAIPUR
(Sponsoring Body : India Education Trust)
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PLASMAPHERESIS DONOR FORM (`COVID-19 Convalescent Plasma)

VOLUNTARY □ / FAMILY VOLUNTARY □ / REPLACEMENT □

(✓) Tick wherever applicable. Cross (x) wherever not applicable. Please answer the following questions correctly. This will help to protect you and the patient who receives your COVID-19 Convalescent Plasma .

PERSONAL DETAILS

S.No.____ DONOR ID: _____Name of Donor (Capital) : _____ Male □ Female □ Age: ____

Occupation: _____ Father's /Husband's Name: _____

Address for communication: _____

Permanent Address: _____

Tel. No. : _____ Mobile No.: _____ Email :_____

Patient's Name: _____ IP No.: _____ Relationship with patient: _____

Have you donated blood/ plasma previously: Yes□ No□ If yes, how many times _____

Date of last Blood/Platelet/Plasma donation : _____

INITIAL SCREENING

Weight (Kg) _____ Height (in cm) ____ Pulse (per min) _____ Temperature _____ BP(mmHg)_____

Blood Group _____SpO2_____ Hb (gm)_____ Hct _____ Plt Count (10°/uL) _____

WBC count _____ HBsAg _____ Anti HIV _____Anti HCV _____

Syphilis _____ MP _____ NAT Test _____ S. Protein _____SARS-CoV-2 IgG Titre _____

Name of staff (screening the donor) _____Sign _____ Date _____ Time_____

- Date of COVID-19 Symptom onset _____ Date of COVID-19 Symptom Cessation _____
- Date of COVID diagnosis(by RT PCR) _____ Date of COVID Negative (RT PCR) _____
- Clinical diagnosis (COVID-19): Mild□ / Moderate□ / Severe □
- Treatment received for COVID-19 : Yes □ No □ Steroids : Yes □ No □
- Have you donated blood within 3 months (for male) or 4 months (for female) or SDP within 48 hours? □ Yes □ No
- Did you experience any ailment difficulty or discomfort during previous donations? □ Yes □ No

  If yes, what was the difficulty(s) _____
- Do you feel well today □ Yes □ No
- Did you have something to eat in the last 4 hours? □ Yes □ No
- Did you sleep well last night? □ Yes □ No

- Have you been refused as a blood donor, or told not to donate? □ Yes □ No
- Will you drive public transport, heavy duty vehicles, piloting, sky diving, deep sea diving, mountaineering or work with machinery after blood donation. □ Yes □ No
- Do you have any reason to believe that you may be infected, by Hepatitis / Malaria / HIV/AIDS / venereal disease? □ Yes □ No
- Are you suffering from Common cold, Cough, Sinusitis, Fever ? □ Yes □ No
- Have you taken antibiotics in last 14 days ? □ Yes □ No
- Have you read the educational material and had your questions answered? □ Yes □ No
- Have you taken alcohol in the past 24 hours? □ Yes □ No
- Do you suffer from migraine frequently : □ Yes □ No (if yes, is it less than 1/week) □ Yes □ No
- Are you taking or have taken any of these in the past 72 hours?
  □ Aspirin □ Steroids □ Other Medicine (Please specify_____)
- In the last 2 weeks have you been vaccinated / immunized for any of the following:
  □ Diphtheria □ Tetanus □ Rabies Prophylaxis □ Plague □ Polio injectable
  □ Hepatitis B Vaccine □ Papilloma virus □ Meningococcal □ Pneumococcal
  □ Pertusis □ Typhoid □ Cholera
- In the last 2 weeks did you suffer from any of the following diseases:
  □ Chicken Pox □ Measles □ Mumps □ Diarrhoea □ Cystitis/ Urinary tract infection
- In the last 4 weeks have you taken any of the following vaccine/serum?
  □ Live attenuated vaccines like Polio, Measles, Mumps, Yellow fever, Japanese encephalitis, Influenza, Typhoid, Cholera, Hepatitis A.
  □ Anti-tetanus serum □ Anti-venom serum □ Anti-diphtheria serum □ Anti-gas gangrene serum
- In the last 3 months have you had any history of Malaria? □ Yes □ No
- In the last 4 months did you suffer from Zika/West Nile infection(s) or visited areas endemic for these infections? □ Yes □ No
- In the last 6 months have you had history of any of the following:
  □ Unexplained weight loss □ Repeated Diarrhoea □ Dengue/Chikungunya □ Minor/Dental surgery (Tooth extraction)
  □ Accidental needle prick □ Continuous fever □ Swollen glands □ Peripheral stem cells
  □ Acute Kidney Infection
- In the last 1 year have you had any history of following: □ Yourself/Spouse/Partner had hepatitis B/C & or Blood Transfusion
  □ Major Surgery □ Typhoid □ Immunoglobulin & Hepatitis B Immunoglobulin □ Rabies vaccine following animal bite □ Hepatitis A/E Inmate of Jail or any other confinement □ Bone or skin graft □ Organ/Tissue or bone marrow donation □ GI endoscopy □ Body piercing □ Tattooing
- In the last 2 years have you had any history of following:
  □ Tuberculosis □ Osteomyelitis
- Do you suffer from or have suffered from any of the following diseases?

□ Heart Disease □ Kidney Disease □ Epilepsy □ Cancer/Malignant Disease □ Diabetes
□ Tuberculosis □ Hepatitis B/C □ Abnormal bleeding tendency □ Jaundice □ Severe allergic disease
□ Convulsion □ Thyroid /other endocrine disorder □ Chronic liver disease/ liver failure □ Asthma on Steroid
□ Lung disease □ Leprosy □ Sexually Transmitted Diseases □ Psychiatric disorder
□ Chronic liver disease/ liver failure □ Kala-azar □ Stomach ulcer □ Autoimmune disorder
□ Hemolytic anemia □ Recipient of organ/ stem cells transplantation

- Female Donors:
  - Are you pregnant □ Yes □ No
  - Have you had an abortion in the last 6 months □ Yes □ No
  - Do you have a child less than one year old? □ Yes □ No
  - Is your child breast-feeding? □ Yes □ No
  - Are you having your periods today? □ Yes □ No

SELF EXCLUSION QUESTIONNAIRE (RISK BEHAVIOUR)

(Please answer all questions honestly. Your answers will be confidential)

- Do you practice safe sex? □ Yes □ No
- Are you HIV Positive or do you think you may be HIV Positive □ Yes □ No
- Is your reason for donating blood to undergo an HIV test? □ Yes □ No

IN THE PAST 6 MONTHS

- Have you had sexual activity by paying money or vice versa? □ Yes □ No
- Have you had multiple sex partners? □ Yes □ No
- Victim of sexual assault? □ Yes □ No
- Sex with someone whose background you do not know? □ Yes □ No

IN PAST 12 MONTHS

- Have you suffered from sexually Transmitted disease? □ Yes □ No
- Have you ever injected yourself with drugs not prescribed by doctor? □ Yes □ No
- Do you think any of the above questions may be true for your sex partner? □ Yes □ No
- Do you consider your blood safe for transfusion to a patient? □ Yes □ No

NOTE: If you are in doubt as to whether or not you should donate blood, please discuss with the staff member. Alternatively you may leave the blood Center without any obligation or you may inform us within 6 hours after donation not to use the blood in case you think your blood might not be safe.

IMPORTANT: Don't donate blood if you may have been exposed to HIV / Hepatitis B & C. **DANGER:** The window period. It refers to the time from when a person is first infected till the person tests positive. During the window period, laboratory tests are negative but the person is still capable of infecting others. Help keep the blood supply as safe as possible by looking .**HONESTLY** at your lifestyle & answering the questions truthfully.

Patient Details:

Patient Name	Request No.	Registration No	Hospital Name	Patient Blood Group

COVID-19 Convalescent Plasma Donation by Plasmapheresis: Information and Consent

1.My Blood will be drawn twice. The first time, 5ml will be drawn for testing and if I am deemed fit for donation then I undergo apheresis procedure.

2. Donation of Plasma by apheresis is a medical procedure and that by donating voluntarily, I accept the risks associated with this procedure.

3. I agree that small samples of my blood will be drawn for laboratory quality control procedures and testing to reduce the risks of transmission of infectious disease to allogenic recipients. My blood will be tested for Hepatitis B, Hepatitis C, HIV I & II, Malaria parasite and Syphilis in addition to any other screening tests required to ensure blood safety. My blood will also be tested for SARS-CoV-2 Ig G antibody test for COVID-19 disease.

4. I understand that I will be notified of any abnormal findings and test results by Blood Center, Mahatma Gandhi Medical College and Hospital, Jaipur . Appropriate education, counselling, and referral will be offered.

5. I prohibit any information provided by me or about my donation to be disclosed to any individual except government agency without my prior permission.

6. Donor information and positive TTI test results are reported to the state or local health department.

7. I authorize the release of information from my medical record to health care providers for the purposes of continuity of care. I understand that the procedure will take approximately 45-60 minutes. To prevent clotting during the procedure, citrate anticoagulant will be added to my blood.

8. I have had the opportunity to request further description and explanation of this procedure from a Blood Center physician, and I understand that I am free to ask any additional questions about the procedure, the benefits or hazards to me from donation, the need for plasma, or any additional information.

9. I understand that blood from a vein in my arm will be sent through a processor where plasma and red blood cells will be separated. Platelets and red blood cells will be returned to me through the same arm.

10. I understand that the medical treatment costs that are incurred due to complications arising directly from the donation will be paid by the hospital.

11. I have been informed that the risks are similar to those involved in a whole blood donation and include chills, nausea, vomiting, fainting or dizziness, hematoma, (bruise at the needle site), blood loss, infection at the needle site, excessive fatigue or pallor, feelings of warmth, convulsions, shortness of breath, light headedness, air embolism, and red cell destruction.

12. In addition to these risks, I understand the possible complications of this procedure include side effects resulting from the substance added to prevent clotting of blood, such as tremor, muscle cramping, numbness, tingling sensations in the fingers or lips, feelings of anxiety, or all of the above. Other reactions include skin rashes, hives, localized swelling, and flushing. In addition, there may be unknown or unforeseen risks involved in this donation, but I am willing to accept the possibility of those risks. I have had my questions answered and a discussion about the likelihood of achieving my goals and any potential problems that might occur during recuperation has taken place.

13. I hereby volunteer to donate plasma by apheresis at Blood Center, Mahatma Gandhi Medical College and Hospital, Jaipur. The amount of plasma donated will be determined by blood Center personnel and will not exceed criteria set by the regulatory authorities.

14. I understand that I may donate plasma twice in one month.

15. I understand that my plasma will be stored and archived for further testing without revealing my identity.

My signing of this consent form indicates that I have read and understood the information provided and my willingness to be a volunteer for automated Plasmapheresis donor. I realize that I may withdraw my consent at any time, the procedure has been explained to me and I have been given the opportunity to ask questions.

Donor Name: _____ Donor Signature _____ Date _____

Medical Officer Name: _____ Medical Officer Signature :_____

Procedure Detail:

DONOR ID _____ Name of equipment: COM.TEC□ TRIMA □ Venous assess: Single Arm □ Double Arm □

Kit Lot No. Expiry_____/_____/___ ACD lot No _____Expiry_____/_____

Normal Saline Lot No:-_____ Expiry _____ Start Time : Hrs_____ Min____ End time :Hrs____ Min_____

Yield Taken _____

RUN Time	WB Flow Rate	WB Processed	Max Inlet Rate	Max Return Rate	ACD Ratio	% of Procedure Completed

Post Hct: Total volume of ACD used: