AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Donor Breast Milk Health Screen

MUST ATTACH DONOR's LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct donor's label

Please tick the box that best describes you:

I am willing to donate breast milk	☐ Yes ☐ No
I am aware:	
I will be screened for the following blood infections: Human Immunodeficiency Virus 1 & 2 (HIV)/Human T Cell Lymphotropic Virus 1 & 2 (HTLV)/Hepatitis B & C/CMV/Syphilis	☐ Yes ☐ No
Do you have or have you ever had:	
Insulin dependent diabetes?	☐ Yes ☐ No
Chronic illnesses? If yes, details ……	☐ Yes ☐ No
A tattoo in the last six months?	☐ Yes ☐ No
Intimate contact with anyone, to your knowledge, who has infectious hepatitis, HIV or HTLV?	☐ Yes ☐ No
Are you taking:	
Any long term prescribed medication (except for oral progesterone-only contraceptive pill, thyroxine or asthma inhaler)?	☐ Yes ☐ No
Taking any herbal medications preparations? If yes, details ……	☐ Yes ☐ No
Growth hormones – including in the past?	☐ Yes ☐ No
Do you:	
Drink more than 3 servings of coffee or caffeinated drinks (i.e. coke, energy drinks) per day?	☐ Yes ☐ No
Alcohol: *Please tick box that best describes your weekly alcohol consumption*	
Currently consume no alcohol	☐ Yes ☐ No
Routinely drink 1-2 standard units of alcohol per week e.g. 1-2 glasses of wine	☐ Yes ☐ No
Routinely drink more than 3 standard units of alcohol per week	☐ Yes ☐ No
Tobacco usage	
☐ Non smoker ☐ Smoker ☐ Nicotine replacement patches or gum	

Do you consume illegal or recreational drugs?	☐ Yes ☐ No
Are you a vegan?	☐ Yes ☐ No
If yes, is your diet supplemented with Vitamin B12?	☐ Yes ☐ No
Are you aware of anything preventing you from donating blood?	☐ Yes ☐ No

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CR9163

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Have you lived or travelled to the UK between 1980-1996 for a total of 6 months or more?	☐ Yes ☐ No
Have you received an organ donation?	☐ Yes ☐ No
Is your own baby in good health and growing well?	☐ Yes ☐ No

Donor name

Donor signature Date

Health Screen ☐ **Suitable** - order serological screen

☐ **Unsuitable** - inform donor and recipient

Serological Screening Date taken: ……

	Results		**Results**
HIV 1 and 2		Hepatitis B and C	
HTLV 1 and HTLV 2		Syphilis	
CMV			

Donor Mother notified of results: ☐ Yes ☐ No Date: ……

Name of notifying clinician: Signed: ……

Comments:

NHI of infant receiving donor milk:

Consent to donation obtained (on donor consent form) ☐ Yes ☐ No

Donor Milk: ☐ **Suitable** ☐ **Unsuitable**

Recipient mother notified of suitability: ☐ Yes ☐ No

Health Professional name

Health Professional signature Date

After this form is completed and signed by a health professional, forward it to Medical Records for filing in the donor's notes.

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