



OXFORD HUMAN MILK BANK DONOR RECORD FORM

Donor Name: .....

Date of Birth: .....

Address (including postcode: .....

NHS Number: .....

.....

(You can find it here: https://www.nhs.uk/nhs-services/online-services/find-nhs-number/

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Are you a previous Milk Donor: YES / NO

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Will this be a one-off or ongoing donation?

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Mobile Number: .....

Home Number: .....

Email Address: .....

GP Name, Address & Telephone Number: .....

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BABY DETAILS

Baby's Name: .....

Baby's Date of Birth: .....

Gestational Age (at birth): .....

Age at enrolment: .....weeks.....

Birth Weight: .....

Place of birth: .....

Admitted to NICU? YES / NO

How many other children do you have? .....

Reason: .....

If you answer YES to any of the following questions, please give details where necessary

Are there any concerns regarding your baby's weight? YES / NO .....

Are you still exclusively breastfeeding your baby? YES / NO .....

Please describe any illnesses your baby has had: .....

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## SERIOLOGICAL SCREENING

Milk Bank staff will complete this section once blood results are received

Date bloods taken: .....	Date samples received: .....
Hepatitis B: .....	Hepatitis C: .....
Syphilis: .....	HIV 1 & 2: .....
HTLV 1 & 2: .....	Date results reported to donor: .....

## MEDICAL HISTORY

If you answer YES to any of the following questions, please give details where necessary

Have you or anyone in your household tested positive or had symptoms of COVID-19, including a high temperature, persistent cough or loss of sense of taste or smell? YES / NO

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Have you or anyone in your household had to self-isolate due to potential exposure to COVID-19? YES / NO

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Are you taking any medication or undergoing any medical therapy? YES / NO

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Have you suffered from any serious illnesses or had any medical interventions in the past year? YES / NO

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Have you ever tested positive or had any recent exposure to infection including HIV 1 or 2, Hepatitis B or C, Human T-Lymphotropic Virus (HTLV) or Syphilis? YES / NO

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Have you received a blood transfusion, blood products or had any piercings, tattoos, or acupuncture within the last 4 months? YES / NO

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Have you recently returned from an area of the world where you may have been exposed to Ebola or Zika viruses, or do you have any reason to believe you may have been infected? YES / NO

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Are you at increased risk of Creutzfeldt-Jacob disease (CJD) or have you had any surgery involving a skin, bone, or tissue graft? YES / NO

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Have you ever received Human Pituitary Growth hormone? YES / NO

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Have you ever suffered from hepatitis / jaundice / liver problems? YES / NO

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Have you ever been exposed to TB or have any family history of TB? YES / NO

Have you ever had donor eggs or sperm IVF (In Vitro Fertilisation)? YES / NO

Have you had any immunisations in the last 6 months? YES / NO

## SEXUAL HEALTH QUESTIONNAIRE

- In the last 4 months have you:
- Had any male sexual partners who in the last 4 months has had sex with another man? YES / NO
- Had any sexual partners who have ever injected, or been injected with, drugs including any cosmetic injection? YES / NO
- Had any sexual partners who are, or you think may be, HIV positive, a carrier of hepatitis B or C, HTLV positive or Syphilis positive? YES / NO
- Had any sexual partners who have Haemophilia? YES / NO
- Had any sexual partners who have travelled to a zika affected area in the last 6 months? YES / NO
- Had any sexual partners who have been sexually active in parts of the World where HIV / AIDS is very common? YES / NO

## LIFESTYLE

How many units of alcohol do you drink in a week? Maximum 1-2 units once or twice a week .....

Do you or any of your household smoke, use nicotine replacement therapy or use a vape/e-cigarette? YES / NO

Do you use recreational drugs, or have you used any recently? YES / NO

Have you ever been injected with, drugs including any kind of cosmetic injection? YES / NO

Are you using any products containing retinol, for example face creams? YES / NO .....

Are you taking any herbal remedies? YES / NO .....

Were you taking any herbal remedies / medication when you were expressing milk? YES / NO

If yes, please state:

Have you ever been exposed to any significant environmental or chemical contaminants? YES / NO

Number of caffeinated drinks per day: (maximum 200mg a day)- Please complete your daily consumption below:

Cups of filter coffee (140mg) .....

Cups of instant coffee (100mg) .....

Cups of tea (75mg) .....

Cans of energy drink (Please give details) .....

Cola drinks (40mg or 354 ml) .....

Do you have a restricted diet e.g., vegetarian, vegan etc.? YES / NO

If yes, please state .....

## EXPRESSING AND STORAGE OF MILK

Do you have a freezer to store milk that is consistently below -18°C? YES / NO

How are you collecting your expressed breast milk?

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Do you already have milk stored in freezer bags or will you start expressing when you receive our sterile bottles?

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### PLEASE INITIAL IF YOU AGREE WITH EACH STATEMENT

I understand the importance of hand washing and personal hygiene .....

I understand that I must sterilise my kit before expressing, and I will be provided with sterilised bottles .....

I understand that milk must be frozen within 24 hours from expression, and I am happy to record my freezer temperature once daily (We can only accept milk that has been expressed within the last 3 months) .....

I understand that all bottles should be clearly labelled and dated .....

I consent to having blood tests necessary to become a breast milk donor and that the sample will be stored within the Microbiology Laboratory for 11 years .....

I consent to my donated breast milk to be issued to babies following health professionals' requests. If my milk is unsuitable to be used as donor milk due to high bacteria counts, I consent to my milk being discarded or occasionally used for research purposes within the Neonatal Unit .....

I consent to my name, address and telephone number being passed to registered milk bank volunteer drivers and / or volunteer blood bike services as required to arrange the collection of milk .....

**Thank you for answering these questions.**

As with blood donors, we need to ensure that all milk donors have tested negative to **Human Immunodeficiency Virus (HIV), Hepatitis C, Hepatitis B, HTLV 1 & 2 and Syphilis**. These tests are required to be taken at the time you would like to register to donate your milk. **Please talk to the Milk Bank Manager.**

**As this would be a routine screening test (as with blood donors) no declaration is necessary on insurance forms.**

#### **Declaration**

I have read the special health precautions needed and to the best of my knowledge, there is no reason why I should not donate my milk. I agree to my blood being tested and to inform the Milk Bank or any lifestyle changes during the donation period.

**Signed:**

**Name (please print):**