Te Whatu Ora
Health New Zealand
Waitaha Canterbury

Human Milk for Our Babies

(Place patient label here or complete details)

NAME:_____

GENDER:_____ DOB: _____ AGE:_____ NHI: _____

ADDRESS:

Human Donor Breast Milk Health Screen

HUMAN BREAST MILK DONOR HEALTH SCREEN

C23003

Please tick the box that best describes you

I am willing to donate my surplus breast milk	☐ Yes	☐ No
I am exclusively breastfeeding/breast milk feeding my baby	☐ Yes	☐ No

I am aware

I will be screened for the following infections: Human Immunodeficiency Virus 1&2 (HIV) / Human T Cell Lymphotrophic Virus 1&2 (HTLV) / Hepatitis B and C and syphilis	☐ Yes	☐ No

Do you have or ever had

Insulin dependent diabetes?	☐ Yes	☐ No
If yes, do you have stable blood sugars?	☐ Yes	☐ No
Any long term illnesses or conditions that require professional follow up?	☐ Yes	☐ No
If yes, details:		
Any illnesses or infections in the last 12 months?	☐ 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
A blood transfusion in the last 4 months?	☐ Yes	☐ No
A vaccination in the last 3 months, eg. Rubella, flu, Covid vax	☐ Yes	☐ No

Have you lived in the United Kingdom, France or the Republic of Ireland between 1980 and 1996 for a cumulative 6 months or more?	☐ Yes	☐ No
Have you travelled to other places in the world recently?	☐ Yes	☐ No
Details:		

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Are you taking

Any long term prescribed medication tablets, creams, injections (except for oral progesterone-only contraceptive pill, thyroxine or asthma inhaler) and/or antibiotics? ☐ Yes ☐ No

If **yes**, please list medications:

Any herbal medication preparations? eg. fenugreek, dietary supplements ☐ Yes ☐ No

If **yes**, details:

Growth hormones – including in the past (eg. as a child)? ☐ Yes ☐ No

If you had a caesarean delivery, did you require Clexane injections? ☐ Yes ☐ No

How many days?

Do you

Drink more than 3 cups of coffee or caffeinated drinks per day (eg. 'V', Demon)? ☐ Yes ☐ No

Alcohol (please tick box that best describes your weekly alcohol consumption)

☐ Currently consume no alcohol

☐ Occasionally drink 1 standard unit of alcohol per day eg. 1 glass of wine

Tobacco usage:

☐ Non-smoker ☐ Smoker ☐ Vaping ☐ Nicotine replacement patches or gum

Other people smoking or vaping in the home, ☐ Yes. *If yes, give details:*

Consume Illegal or recreational drugs? ☐ Yes ☐ No

Do you follow a vegan diet? ☐ Yes ☐ No

If yes, is your diet supplemented with Vitamin B12? ☐ Yes ☐ No

I am aware that all information collected in relation to the use of my donated milk could be shared with CDHB staff and access holders and will be placed on my medical records ☐ Yes ☐ No

Donor's name

Donor's signature _____ Date

Name of Health Care Professional _____ Job Title

Signature of Health Care Professional _____ Date