Canterbury District Health Board
Te Poari Hauora ō Waitaha
Human Milk for Our Babies

SURNAME ..... NHI .....
FIRST NAME ..... DOB .....
ADDRESS .....
..... POSTCODE .....
(or affix patient label)

Human Donor Breastmilk Health Screen

HUMAN DONOR BREASTMILK HEALTH SCREEN

Please tick the box that best describes you

I am willing to donate my surplus breastmilk	☐ Yes	☐ No
I am exclusively breastfeeding/breastmilk 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	☐ Yes	☐ No
I am aware that my antenatal screening results will be accessed (including 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? If yes, *details*	☐ Yes	☐ No
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. whooping cough, influenza, rubella?	☐ 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

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? If yes*, please state:*	☐ Yes	☐ No
Any herbal medication preparations? eg. fenugreek, dietary supplements If yes, *details*	☐ Yes	☐ No
If you had a caesarean delivery did you require Clexane injections? How many days?	☐ Yes	☐ No
Growth hormones – including in the past (eg. as a child)?	☐ Yes	☐ No

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 ☐ Nicotine replacement patches or gum ☐ Other people smoking in the home, if yes *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

HEALTH CARE PROFESSIONAL'S NAME DESIGNATION

HEALTH CARE PROFESSIONAL'S SIGNATURE DATE

C230053

SURNAME ..... NHI .....

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Human Milk for Our Babies

Human Donor Breastmilk Health Screen

Serological Screening

Date taken: .....

Date reviewed: .....

	Results
HIV 1 and 2	
HTLV 1 and HTLV 2	
Hepatitis B and C	

	Date	Result
Syphilis		

Donor mother notified of results? ☐ Yes ☐ No Date:

NOTIFYING CLINICIAN NAME SIGNATURE

Comments:

AFTER THIS FORM IS COMPLETED AND SIGNED BY A HEALTH PROFESSIONAL, FORWARD IT TO MEDICAL RECORDS FOR FILING IN THE DONOR'S NOTES