Health New Zealand
Te Whatu Ora

(Place patient label here or complete details)

NAME:_____

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

ADDRESS:

Human Milk for Our Babies

Human Donor Breast Milk Health Screen

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? *If yes, details:*	☐ Yes	☐ No
Any illnesses or infections in the last 12 months? *If yes, detail below:*	☐ Yes	☐ No
A tattoo in the last six months?	☐ Yes	☐ No
Intimate contact with anyone, to your knowledge, who has infectious hepatitis, MPox (monkey pox), HIV or HTLV? *If yes, detail below:*	☐ Yes	☐ No
A blood transfusion in the last 4 months? Date of transfusion:	☐ Yes	☐ No
Any 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? *If yes, detail below:*	☐ Yes	☐ No

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HUMAN BREAST MILK DONOR HEALTH SCREEN C230053

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**, list medications below:* ☐ Yes ☐ No

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?

Date Clexane started Date Clexane completed

Do you

Drink more than 3 cups of coffee or caffeinated drinks per day (e.g. V, Mother)? ☐ Yes ☐ No

Drink alcohol containing beverages (e.g. wine, beer, spirits)
Please tick box that best describes your weekly alcohol consumption

☐ Currently consume no alcohol

☐ Occasionally drink 1 – 2 standard beverages containing alcohol per week.
(See Health New Zealand | Te Whatu Ora guide to standard drinks)

Tobacco usage:

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

☐ Other people smoking or vaping in the home. *If yes, detail below:*

Use 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 Health NZ |Te Whatu Ora 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