Health History for COVID-19 Potential Donor

All Questions Must be Answered by the Potential Donor

1. Do you agree with having your information shared with a blood collection center? ☐ Yes ☐ No
2. First Name:
3. Last Name:
4. Date of Birth:
5. What is the best email address to reach you?
6. What is the best phone number to reach you?
7. What DATE did your symptoms start?
8. What DATE were you diagnosed with COVID-19?
9. Are you still symptomatic? ☐ Yes ☐ No If not, WHAT DATE did your symptoms resolve?
10. If your donation is being organized by a GROUP, enter GROUP name here:
11. If you were recruited to donate by a hospital, enter hospital name here:
12. What is your blood type? ? ☐ Unknown

    ☐ O Negative ☐ O Positive ☐ A Negative ☐ A Positive
    ☐ B Negative ☐ B Positive ☐ AB Negative ☐ AB Positive
13. Is there any other important information about your donation we need to know?

Signature Date

if you are donating for a specific patient and you have the following information, please provide below

1. Patient blood type ☐ O Negative ☐ O Positive ☐ A Negative ☐ A Positive ☐ B Negative ☐ B Positive ☐ AB Negative ☐ AB Positive
2. eIND _____ or EAP _____ number
3. Hospital where patient is being treated

ONEBLOOD, INC. AUTHORIZATION FOR RELEASE OF DONOR MEDICAL INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Donor name: _____

Persons/organizations providing the Medical, Claim or Employment Information: any physician, surgeon or any medical professional person, dentist, hospital, rehabilitation/convalescent/custodial facility, ambulance service provider, nurse or health insurance company. In addition, any liability insurer or employer.

Organization receiving the Medical Information: ONEBLOOD, INC..

Specific description of Medical Information requested: any records in the possession of the physician, surgeon or any medical professional person, dentist, hospital, rehabilitation/convalescent/custodial facility, ambulance service provider, nurse or health insurance company regarding the donors medical history and physical condition both before and after the date of signature of this authorization, regardless of the date of occurrence.

The purpose of the use or disclosure: To be used to for the purpose to verify and evaluate donor suitability for COVID-19 CONVALESCENT PLASMA DONATION

Section B: Must be completed for all authorizations

The donor must read the following statements:

1. I understand that this authorization will expire 90 days from the date it is signed.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.
3. I understand that I may see and copy the information described on this form if I ask for it, and I acknowledge my right to obtain a copy of this form.

_____ _____

(Signature) Date

Please save this completed document and upload it when you submit the online form at www.oneblood.org/CCP/CCP-form-donor.stml.