Canterbury District Health Board
Te Poari Hauora ō Waitaha

Human Milk for Our Babies

SURNAME ..... NHI .....
FIRSTNAME .....
DOB ..... AGE .....
ADDRESS .....

Human Donor Breastmilk Health Screen

Please tick the box that best describes you

I am willing to donate breastmilk	☐ Yes	☐ No
I am exclusively breastfeeding 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
Any long term illnesses, such as tuberculosis? 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?	☐ 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 (except for oral progesterone-only contraceptive pill, thyroxine or asthma inhaler) and/or antibiotics?	☐ Yes	☐ No
Any herbal medication preparations? If yes, details	☐ 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 ☐ Routinely drink 1-2 standard units of alcohol per week, eg. 1-2 glasses of wine ☐ Routinely drink more than 3 standard units of alcohol per week ☐		
Tobacco usage ☐ Non-smoker ☐ Smoker ☐ Nicotine replacement patches or gum ☐ Other people smoking in the home		
Consume Illegal or recreational drugs?	☐ Yes	☐ No
Are you a vegan?	☐ Yes	☐ No
If yes, is your diet supplemented with Vitamin B12?	☐ Yes	☐ No
I am aware that all information collected in relation to my baby's use of donor milk could be shared with CDHB staff and access holders and will be placed on my baby's general medical record	☐ Yes	☐ No

Donor name

Donor signature Date

HUMAN DONOR BREASTMILK HEALTH SCREEN C230053

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

FIRSTNAME .....

DOB ..... AGE .....

ADDRESS .....

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.