Rotary Community Breast Milk Bank

SURNAME…………………………………………………..NHI…………………………….
FIRST NAME…………………………………………………DOB…………………………..
ADDRESS…………………………………………………………………………………………
……………………………………………………………………..POST CODE………………..
Baby's DOB…………………………… Ethnicity…………………………………………

Woman Wishing to Donate Breast Milk: Consent

	Yes	No
I consent to donate my extra breast milk to the Rotary Milk Bank	θ	θ
I have read the handout about donating milk for babies through the Rotary Milk Bank	θ	θ
I have understood the process for collecting, storing, and the transportation of my milk to the Rotary Milk Bank at St George's Hospital	θ	θ
I have read and signed the lifestyle questionnaire and to the best of my knowledge there is no reason I should not donate my milk	θ	θ
I understand I will need to be screened for the following blood borne infections prior to donating my breast milk: HIV 1 & 2. Testing twice; Hepatitis B antigen; Hepatitis C; HTLV-1 & 2; Rubella; Syphilis	θ	θ
I consent to all information collected in relation to my donation being shared with Rotary Milk Bank staff as appropriate	θ	θ
I understand I will only receive general information about my donation but will receive regular updates about the work of the Rotary Milk Bank.	θ	θ
I wish to be contacted if my milk is unable to be used for any reason	θ	θ
I understand that I can cease donating at any time.	θ	θ

Donor's signature:……………………………………………………………………………………………………Date: ……………………………………..

STAFF USE ONLY

Statement of health care professional with an appropriate knowledge of the Rotary Breast Milk Bank policies.

I have discussed the process with the woman and explained the following:-

- Information about donating breast milk
- How to collect and store the milk
- Reasons for temporarily stopping donation
- The screening process

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Name of Health Care Professional

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Signature of Health Care Professional Date