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| --- | --- |
| **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 |  |  |
| I have read the handout about donating milk for babies through the Rotary Milk Bank |  |  |
| I have understood the process for collecting, storing, and the transportation of my milk to the Rotary Milk Bank at St George’s Hospital |  |  |
| 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 |  |  |
| 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. I understand I will need to be re-tested six months after my first tests if I am still donating.  Original Testing Date/s: …………………………………………...…Six month re-test Due Date: …………………….... |  |  |
| I consent to all information collected in relation to my donation being shared with Rotary Milk Bank staff as appropriate |  |  |
| I understand I will only receive general information about my donation but will receive regular updates about the work of the Rotary Milk Bank. |  |  |
| I wish to be contacted if my milk is unable to be used for any reason |  |  |
| I understand that I can cease donating at any time. |  |  |

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, given training in the use of equipment, and education on the following:-

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

………………………………………………………………………………………………………………………………………………………………………………………….Name of Health Care Professional

…………………………………………………………………………………………………………………………………………………………………………………………..Signature of Health Care Professional Date PTO

**Data collection from donor mothers.**

We request your consent to gather unidentified data for the purposes of audit. The initial audit of donors will collect data on:-

* Length of time milk was donated Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Finish Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Amount donated Litres: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How many children have you breast fed including this baby? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How did you hear about our service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I agree for this information to be used for the purposes of audit, and I agree that Rotary Milk bank staff can complete the Finish Date and Amount donated.

Donor’s signature:…………………………………………………………………………………………………………Date: ……………………………………..