

II. PERSONAL DATA AND PRIVACY

When giving blood, you are asked to answer a number of questions regarding your health, lifestyle and any foreign travel you have undertaken. These questions enable us to assess whether or not it is safe for you to give blood, and for others to receive it.

Additional personal information (address, e-mail, telephone number) is also collected and recorded for administrative purposes so that we can invite you to donate again, send test results if needed, notify you of upcoming events to promote blood donation, and to share information about giving blood.

This personal information will be kept strictly confidential and will not be used for any other purpose. Moreover, your personal medical data are protected under medical confidentiality legislation.

In accordance with the Belgian law, the medical questionnaires which you complete prior to giving blood, will be retained for 15 years. Data enabling the donated blood and any derived products to be identified to ensure full traceability will be retained for a minimum of 30 years and a maximum of 40 years.

The responsible for the treatment of the data is the Service du Sang of the Croix-Rouge de Belgique (Rue du Fond du Maréchal 8 - 5020 Suarlée).

In compliance with the General Data Protection Regulation, you have the right to access these data, to request to have them corrected and to have them communicated to an authorised individual (portability) at any time. You can submit a request relating to your personal data by completing the relevant form available at <https://www.croix-rouge.be> under the "Vie Privée" ("Privacy") section.

III. INFORMED CONSENT

With every blood donation, after you have completed the confidential medical questionnaire, you will be asked to sign this informed consent form.

This means that, once the blood donation process has been explained to you in full (how the process works, the tests carried out, the benefits and risks for the receivers, the risks for the donor, how we process your personal data, etc.) and you have received answers to your questions:

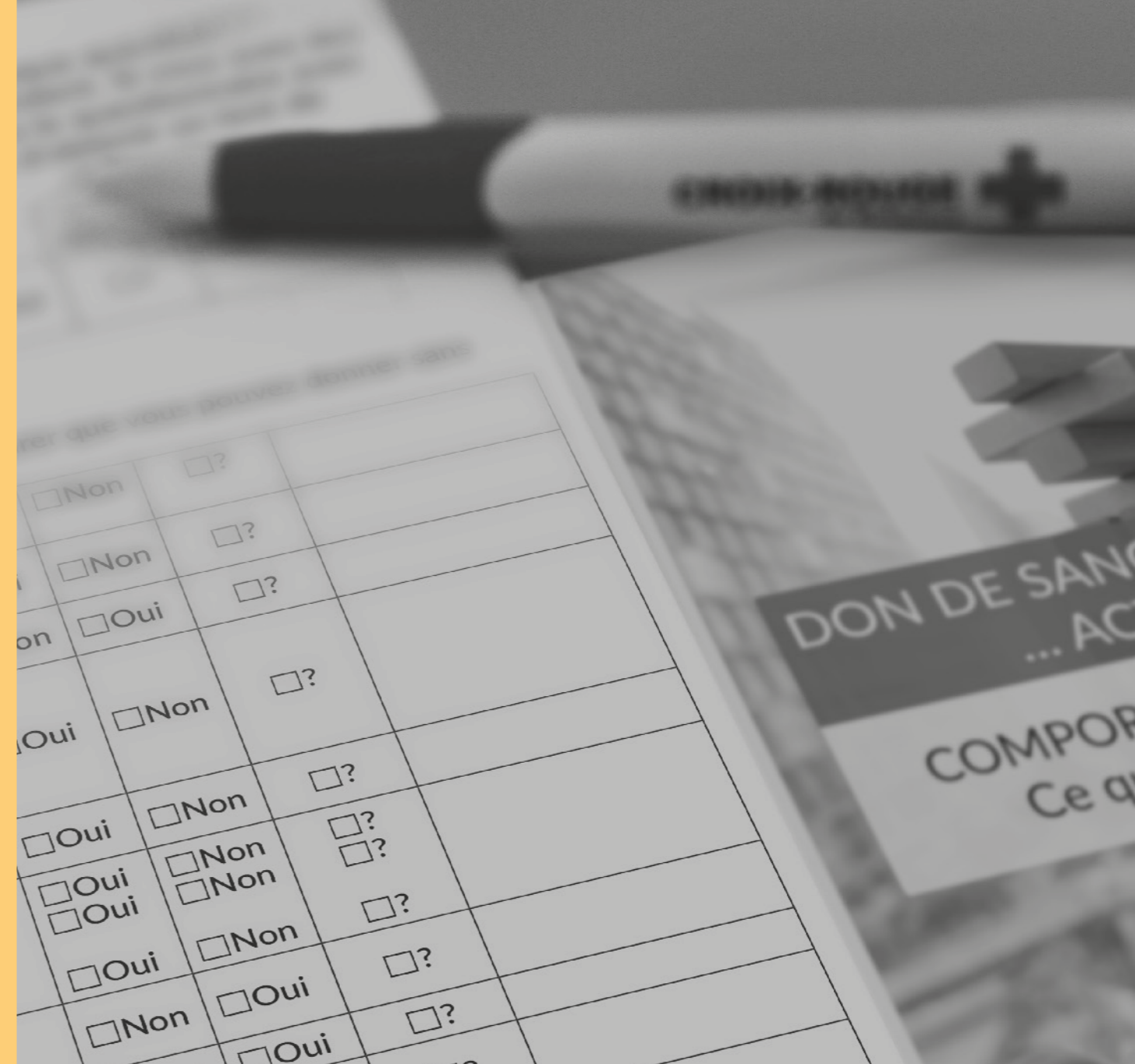
- You formally consent to donate blood, by answering the questions below and signing;
- You confirm that the details you have supplied are truthful;
- You give or decline consent for one or more components or samples of your blood to possibly be used in medical or scientific research.

You have the right to decide not to proceed with the donation before the process begins, and to stop the process at any time without feeling embarrassed or ashamed.

| | |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| I authorise the Service du Sang to take and analyse my blood and agree that it is transfused to one or several patients | <input type="checkbox"/> Yes |
| I declare that, to the best of my knowledge, the information that I give is exact and complete | <input type="checkbox"/> Yes |
| I accept that, in certain cases, one or several components of my blood may be used for medical or scientific research | <input type="checkbox"/> Yes <input type="checkbox"/> No |

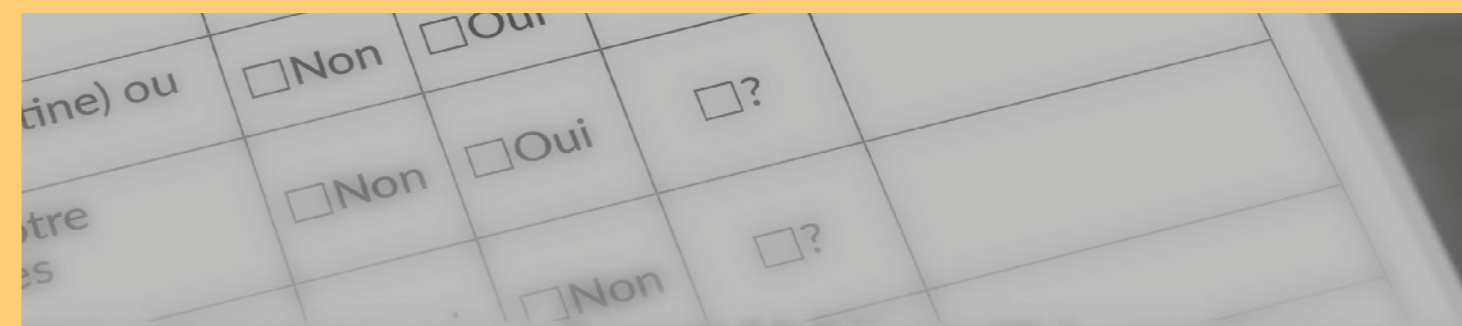
| | |
|-----------------------------|-----------------------------|
| Signature of the donor | Signature of the examiner |
| | |
| Date..... / / 20..... | Date..... / / 20..... |
| Donation nr | |

THANK YOU VERY MUCH FOR YOUR INITIATIVE, WHETHER YOU GIVE BLOOD TODAY OR NOT



CONFIDENTIAL MEDICAL QUESTIONNAIRE AND INFORMED CONSENT

Service du Sang



I. CONFIDENTIAL MEDICAL QUESTIONNAIRE

Before giving blood, we ask you to complete this questionnaire. Please read each question carefully and answer truthfully: this is important for the health and safety of yourself and of those who will receive the products derived from your gift. If you are unsure about any of your answers, please discuss this with the doctor or nurse who will review the completed questionnaire with you. They will be able to address any queries you may have. Never give blood for the purpose of obtaining a screening test. The doctor or nurse will be happy to advise you on how to go about this.

| | | | I don't know | Column reserved for the examiner |
|---|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------|----------------------------------|
| 1 | Have you received, read and understood the information provided about blood donation, at risk behaviour and blood transmitted diseases (document "Giving blood responsibly, Risk behavior, what you need to know")? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |

A HEALTH AND MEDICAL TREATMENTS

Why do we ask questions about your health?

To find out about any illnesses, treatments or other situations which could be contraindications for giving blood, and to safeguard your own personal health as well as the health of the people who will receive your blood products.

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| 2 | If you have ever given blood: did your last donation go well? Date of your last donation: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 3 | After giving blood, will you undertake a physical activity, practice a sport or work in a security post? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 4 | Are you feeling well and in good health? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |
| 5 | Do you have or have you ever had a condition like: cardiovascular disease (irregular heartbeat, chest pain, heart attack...), stroke, epileptic seizures, blood disease, cancer, diabetes, severe allergy, or a stomach, intestine, lung, auto-immune or other disease? If yes, which one? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 6 | Are you coming to give blood as part of a treatment for hemochromatosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 7 | - Have you ever been operated on your brain or spinal cord? - Have you or a family member of yours been diagnosed with Creutzfeldt-Jakob Disease? - Have you received treatment with growth hormones before 1989? | <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> ? <input type="checkbox"/> ? | |
| 8 | Have you ever had a positive test for HIV (AIDS), hepatitis, syphilis or HTLV? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |
| 9 | Have you ever been hospitalized, operated or had a tissue transplant? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |
| 10 | Do you have or have you ever had regular medical follow-up with a general practitioner or a specialist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 11 | Since your last blood donation (or within the last 6 months, if this is your first donation): - Have you been vaccinated or have you followed a desensibilisation therapy? - Have you taken any medication (even an aspirin)? If yes, which one(s)? | <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> ? <input type="checkbox"/> ? | |
| 12 | Within the last 3 years, have you taken Neotigason® (acitretine) or Tigason® (etretinate)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |
| 13 | Since your last blood donation (or within the last 4 months, if this is your first donation), have you been ill, had a fever (≥ 38°C) or have you undergone any medical examination? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |
| 14 | Since your last blood donation (or within the last 4 months, if this is your first donation), have you had a skin rash (pimples, patches, red spots) or have you been bitten by a tick? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 15 | Have you been to the dentist within the last 7 days? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 16 | Have you ever received blood? If yes, when?, In which country? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |

FOR WOMEN

| | | | | | |
|----|--------------------------------------------------------------------------------------|-----------------------------|------------------------------|----------------------------|--|
| 17 | Have you ever been pregnant (including a miscarriage or an abortion)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |
| 18 | Are you currently pregnant or have you been pregnant since your last blood donation? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |

B STAYS IN FOREIGN COUNTRIES

Why do we ask questions about foreign travel?

You could be a carrier of a blood-borne disease, contracted while travelling in certain countries and which may go unnoticed or be present in a silent way for some time. This is why it may be necessary to wait a while before giving blood in order not to transmit this type of disease to the patients who will receive your blood products.

| | | | | I don't know | Column reserved for the examiner |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------|----------------------------------|
| 19 | In which country were you born and where did you live in the first 5 years of your life? | | | | |
| 20 | Between 1/1/1980 and 31/12/1996, have you spent at least 6 months (total duration of stay) in the United Kingdom (England, Scotland, Wales, and/or Northern Ireland)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 21 | Did your mother live in Central or South America before your birth? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> ? | |
| 22 | Since your last blood donation (or since you were born, if this is your first donation): - Have you had malaria or Chagas disease? - Have you travelled outside Belgium (even for one day)? If yes, in which country have you been (including a stop-over or transit)? | <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> ? <input type="checkbox"/> ? | |

C POSSIBLE EXPOSURE TO AN INFECTIOUS DISEASE THAT CAN BE TRANSMITTED BY BLOOD

Why do we ask such diverse and intimate questions?

It may be necessary to wait a while before giving blood if there is a risk that you have been exposed to a blood-borne infection. Indeed:

- Our laboratory does not screen donated blood for all infectious agents (e.g. flu, glandular fever, etc.)
- In addition, infectious agents which are routinely screened for (syphilis, HIV (AIDS), hepatitis B and C) have a period (which varies in length) known as the "silent window" during which screening tests are negative despite the infectious agent being present in the blood and possibly transmitted.

GENERAL RISKS

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|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 23 | Have you ever used intravenous or intramuscular hard drugs, doping products or anabolic steroids that were not prescribed by a doctor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 24 | Since your last blood donation (or within the last 4 months, if this is your first donation) have you: - Had surgery or an endoscopy (gastroscopy, colonoscopy, rhinoscopy, arthroscopy ...)? - Had a treatment with needles: tattoo (including permanent make-up), piercing (including earrings), mesotherapy, acupuncture? - Been in contact with human blood by means of an injection, bite, lesion or splashing? - Used (sniffed) intranasal drugs? - Been living with a person who had a positive hepatitis B test? - Been in contact with a person suffering from another contagious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> ? <input type="checkbox"/> ? <input type="checkbox"/> ? <input type="checkbox"/> ? <input type="checkbox"/> ? <input type="checkbox"/> ? | |

SEXUAL RISKS

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|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|
| 25 | Since your last blood donation (or within the last 4 months, if this is your first donation), have you had sexual contact with a new partner, even an occasional one* ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> ? | |
| 26 | Since your last blood donation (or within the last 12 months, if this is your first donation) did your partner, to the best of your knowledge, or did you yourself have sexual contact*: - In exchange for money, goods or services? - With more than one partner during the same period of time? | <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> ? <input type="checkbox"/> ? | |
| 27 | Within the last 12 months, have you had a sexual partner* who, to the best of your knowledge: - Has had a positive test for HIV (AIDS), hepatitis B, hepatitis C or HTLV? - Has ever used intravenous or intramuscular hard drugs? - Was born in a country outside of Western Europe and who had been living in Europe for less than 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> ? <input type="checkbox"/> ? <input type="checkbox"/> ? | |
| 28 | Within the last 12 months, have you had sexual contact*: FOR MEN: with a man? FOR WOMEN: with a man who, to the best of your knowledge, has had sexual contact with another man? | <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> ? <input type="checkbox"/> ? | |

* with or without a condom

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