Health New ZealandTe Whatu Ora

MATERNITY SERVICES

NHI	WARD			
SURNAME				
FIRST NAME				
GENDER DOB	AGE			
(or affix patient label)				

Unpasteurised Breastmilk Donor Health Screen

I am willing, and have consented, to donate breastmilk surplus to my baby's needs	☐ 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 / Cytomegalovirus CMV / Syphilis	☐ Yes	□ No
I am aware that my antenatal screening results will be accessed	☐ Yes	□No
Do you have or ever had		
Insulin dependent diabetes? If yes, do you have stable blood sugars?	☐ Yes ☐ Yes	□ No
Any long term illnesses or conditions that require professional follow up? If yes, details	☐ Yes	□No
Any illnesses or infections in the last 12 months? If yes, details	☐ Yes	□No
A tattoo in the last six months? Intimate contact with anyone, to your knowledge, who has infectious hepatitis, HIV or HTLV?	☐ Yes	□ No
A blood transfusion in the last 4 months? A vaccination in the last 3 months, eg. whooping cough, influenza, rubella?	☐ Yes	□ No
Have you travelled to other places in the world recently?	☐ Yes	□ No
Are you taking		
Any long term prescribed medication tablets, creams, injections (except for oral progesterone-only contraceptive pill, thyroxine or asthma inhaler) and/or antibiotics? If yes, please state:	☐ Yes	□ No
Any herbal medication preparations? eg. fenugreek, dietary supplements If yes, details	☐ Yes	□ No
If you had a caesarean delivery did you require Clexane injections? How many days?	Yes	
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	☐ Yes	
Occasionally drink 1 standard unit of alcohol per day eg. 1 glass of wine	☐ Yes	
Tobacco usage: ☐ Non-smoker ☐ Smoker ☐ Nicotine replacement patches or gum		
☐ Other people smoking in the home, if yes details		
Consume Illegal or recreational drugs?	☐ Yes	□No
Do you follow a vegan diet?	☐ Yes	□No
If yes, is your diet supplemented with Vitamin B12?	☐ Yes	☐ No
I am aware that all information collected in relation to the use of my donated milk could be shared with Health NZ Waitaha staff and access holders and will be placed on my medical records	☐ Yes	□No
DONOR NAME		

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☐ Unsuitable – inform donor and recipient				
SEROLOGICAL SCF	REENING D	ate taken:		
	Results		Results	
HIV 1 and 2		CMV IgG		
HTLV 1 and HTLV 2		CMV IgM		
Hepatitis B and C		Syphilis		
Danay mathay natified	of recultor Ves No	Deter		
Donor mother notified	of results: Yes No	Date:		
Name of notifying clinician	า:	Signed:		
Comments:				
NHI of infant receiving of	lonor milk:			
Consent to donation obta	ined (on Unpasteurised Breastn	nilk Use Donor Consent (Ref.24052	32)): Yes No	
DONOR MILK	Suitable Suitable			
	Unsuitable (update Infan	t Feeding Record Ref.2400431)		
Recipient mother notified	of suitability: Yes No			
HEALTH PROFESSIONAL NAME				
HEALTH PROFESSIONAL SIGNATURE		DATE		

AFTER THIS FORM IS COMPLETED AND SIGNED BY A HEALTH PROFESSIONAL:

- Keep a copy at the facility for the duration of the time the donors milk is being used
- 2. Forward a copy to clinical records to be filed in the donor's notes