Helensville Birthing Centre
TE PUNA WHĀNAU KI TE AWAROA

Breastmilk Donor Health Screening Questionnaire

Name:			
Address:			
Phone: **DOB:** **NHI:**			
Email:			
The date I gave birth was		/	/
I am willing to donate my surplus breast milk		Yes	No
I anticipate donating 110mls (or more) at a time		Yes	No
I anticipate donating on an ongoing basis	Not sure	Yes	No
I have milk available that has been collected and stored as per the 'Instructions for Milk Bank Donors' page on HBC website. Please state approximate amount of milk.			

I am aware I will be screened for the following infections:

Human Immunodeficiency Virus 1&2 (HIV) (routinely tested for during pregnancy) Hepatitis B and C (routinely tested for during pregnancy) Syphilis (routinely tested for during pregnancy) Human T Cell Lymphotrophic Virus 1&2 (HTLV)	Yes	No

Do you have or ever had?

Insulin dependent diabetes?	Yes	No
If yes, do you have stable blood sugars?	Yes	No
Any long term illnesses or conditions that require professional follow up? If yes, please detail:	Yes	No
Any illnesses or infections in the last 12 months? If yes, please detail below:	Yes	No
A tattoo in the last six months?	Yes	No
Intimate contact with anyone, to your knowledge, who has infectious hepatitis, MPox (monkey pox), HIV or HTLV? If yes, please detail below.	Yes	No
A blood transfusion in the last 4 months? Date of transfusion:	Yes	No
Any vaccination in the last 3 months, eg. Rubella, flu, Covid vax	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? If yes, please detail below:	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 list medications below:	Yes	No
Any herbal medication preparations? eg. fenugreek, dietary supplements If yes, please detail:	Yes	No
Growth hormones – including in the past (eg. as a child)?	Yes	No
If you had a caesarean delivery, did you require Clexane injections? How many days? Date Clexane started: Date Clexane completed:	Yes	No

Do you;

drink more than 3 cups of coffee or caffeinated drinks per day (e.g. V, Mother)?	Yes	No
currently consume no alcohol	Yes	No
occasionally drink 1 – 2 standard beverages containing alcohol per week. (See Health New Zealand | Te Whatu Ora guide to standard drinks)	Yes	No
frequently drink more than 2 standard beverages containing alcohol per week	Yes	No

Tobacco usage (please circle):

Non-smoker Smoker Vaping Nicotine Replacement patches of gum Other people smoking/vaping in home Please give details;		
Do you use illegal or recreational drugs?	Yes	No
Do you follow a vegan diet?	Yes	No
If so, 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 |Te Whatu Ora staff and access holders and be placed on my medical records	Yes	No
Donor's name: Donor's signature: Date:		

Thank you!

Milk Bank use		
	Staff name: Staff signature: Date:	

Optional Information – that could be provided (without identifying you) to the mother receiving your breastmilk. See below for an example of how this information may be provided.

Is there anything more you'd like to tell us about yourself or your baby?

What are your reasons / motivations for donating your breastmilk?

What has your breastfeeding journey been like?

Is there any message of encouragement you would like to give the mother receiving your breastmilk?

Is there anything you would like the mother receiving your milk to know?

Thank you ☺