



MARROW DONOR REGISTRY-INDIA (MDRI)

MUMBAI

Sr. No. _____

DONOR REGISTRATION AND CONSENT FORM

FIELDS MARKED IN  ARE COMPULSORY


BARCODE NO.: _____ DATE: _____ LOCATION: _____

(PLEASE FILL THE FORM IN CAPITAL LETTERS)

FIRST NAME

MIDDLE NAME

SURNAME



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DD DD MM MM YY YY YY YY

DATE OF BIRTH

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MALE FEMALE

GENDER

BLOOD GROUP

 _____
PLACE OF ORIGIN (NATIVE PLACE)

 _____
MOTHER TONGUE

 _____
CASTE/SUB CASTE

LANDLINE NUMBER

 _____
MOBILE NUMBER

E-MAIL ADDRESS

CURRENT ADDRESS:

PERMANENT ADDRESS:

CITY : _____ STATE: _____
PINCODE :

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CITY : _____ STATE: _____
PINCODE :

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ALTERNATE ADDRESS:

Please Answer the following Questions Correctly

Have you donated Blood/Platelets in the past ? Yes No If yes, when _____

Have you been refused as a blood donor ? Yes No If yes, when _____

Have you had any of the following illness in the past?

Bleeding Tendency	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Fainting attacks	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
High BP	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
HIV/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Hepatitis/Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Malaria	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Have you ever received any blood Transfusion?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____
Do you need to take any Medicines regularly?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____

Informed Consent :

I hereby consent to the taking of a blood sample in order to carry out the typing. I transfer ownership of the blood sample to the MDRI and agree that my sample is kept and used for HLA typing. I have been informed by MDRI that the typing of my blood sample and the admission into the database serve the purpose of finding a matching donor for patients.

I confirm the correctness of my personal data above and I agree that it is stored at MDRI in order to search for donors. I have consent to be a voluntary Marrow Donor and I have the Option to withdraw at any time. I am willing to come for confirmatory test whenever required.

DATE : _____ PLACE : _____ DONOR SIGNATURE: _____

Signature of Counselor

Signature of Medical Officer

Identity Confirmation Proof

All above information is confidential and is for office use only.

(The Application will not be processed if the Form is not duly completed.)