Blood Bank of Hawaii

Inquiry Date: _______________

# CCP Donor Questionnaire

| **NAME** | | **DATE OF BIRTH** | **GENDER** |
|---|---|---|---|
| ______________________ | ______________________ | ____________ | ______ |
| First | Last | mm / dd / yyyy | M / F |

| **EMAIL** | **PREFERRED PHONE NUMBER** |
|---|---|
| ____________________________________________ | __________________________ |

## Initial Contact

1. Was your COVID-19 diagnosis confirmed by a lab test?

   ☐ YES ☐ NO ☐ UNSURE

2. Are you currently experiencing any symptoms?

   ☐ YES ☐ NO

3. What was the date of your first symptom? ____________

4. What was the date of your last symptom? ____________

5. Did you receive a CCP plasma transfusion as part of your treatment for COVID-19?

   ☐ YES (If yes, date of transfusion: ____________) ☐ NO

6. Did you receive a Covid-19 Vaccine?

   ☐ YES (If yes, date and type of vaccine: __________/__________) ☐ NO

7. Have you completed a follow up test that was negative for COVID-19?

   ☐ YES ☐ NO

## Follow-Up

1. Have you had a chance to review the eligibility requirements on our website?

   ☐ YES ☐ NO

2. **(If Female)** Do you have a history of pregnancy?

   ☐ YES (If yes how many births _____?) ☐ NO

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Office Use only: Sample only appt: ____________

Existing BBH donor: ☐ YES ☐ NO DID: _______________