

DONOR QUESTIONNAIRE – Faeces donor (FMT Start)**All health information will be treated confidentially.****Full name:** _____ **Personal ID number:** _____

Since your last visit:	No	Yes
Do you feel completely healthy?	<input type="checkbox"/>	<input type="checkbox"/>
What is your weight in kg?.....	_____	_____
What is your height in cm.....	_____	_____
Do you work in childcare with close contact with children, in food handling (e.g., employed in food companies, kitchens, or institutions preparing and/or serving food to others), or as healthcare staff with direct contact with patients who are particularly vulnerable to infections (e.g., premature infants or severely immunosuppressed patients)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had allergies (e.g., asthma, hay fever, hypersensitivity to medicines)?.....	<input type="checkbox"/>	<input type="checkbox"/>
..		
Do you suffer from chronic illnesses: Crohn's disease, ulcerative colitis, coeliac disease (gluten intolerance), rheumatoid arthritis or other autoimmune joint disease, multiple sclerosis, psoriasis, heart disease, kidney disease, diabetes, mental illness, or depression?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your close relatives (parents or siblings) suffer from: Crohn's disease, ulcerative colitis, coeliac disease (gluten intolerance), or bowel cancer?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had cancer?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you previously had bowel surgery (other than appendectomy)?.....	<input type="checkbox"/>	<input type="checkbox"/>
In the last 6 months, have you had acute bowel disease (e.g., diarrhoea, blood or mucus in stools, vomiting)?.....	<input type="checkbox"/>	<input type="checkbox"/>
In the last 6 months, have you received treatment in a hospital or clinic?.....	<input type="checkbox"/>	<input type="checkbox"/>
In the last 6 months, have you been at possible risk of contracting blood-borne or sexually transmitted diseases (e.g., sexual risk behaviour, tattoo/piercing/acupuncture, sharing needles or syringes, blood transfusion, or exposure to HIV or infectious hepatitis)?.....	<input type="checkbox"/>	<input type="checkbox"/>
In the last 4 months, have you had anal intercourse with a new contact/partner?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medication daily or periodically?.....	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months, have you received antibiotic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your household been ill since your last stool donation?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your household been diagnosed with multi-resistant bacteria (e.g., MRSA or CPO)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your household had weekly or more frequent contact with live pigs or mink in the last 6 months?.....	<input type="checkbox"/>	<input type="checkbox"/>

Since your last visit:	No	Yes
In the last 6 months, have you travelled outside Denmark?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed changes in your stool since your last stool donation?.....	_____	_____
Based on the Bristol Stool Scale: assess your normal stool (/, 1-7).....	_____	_____
Based on the Bristol Stool Scale: assess today's stool (/, 1-7).....	_____	_____
Time of toilet visit (date and time).....	<input type="checkbox"/>	<input type="checkbox"/>
I confirm that the stool is mine.....		
Do you accept that staff from the Blood Bank and Immunology Department may contact you regarding donation, and that you may withdraw your consent at any time?.....	<input type="checkbox"/>	<input type="checkbox"/>
Will you commit to contacting the Blood Bank and Immunology Department if your health status changes?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any additional comments?.....		
Comment: _____		

Date

Donor Signature

Reserved for Blood and Tissue Centre Midt

Interview conducted by (Region ID)	
Time (Receipt of stool donation)	

For emergency procedures (label, comments etc.):

Remember to complete a Q-reg

Linking of CPR and donation number in ProSang (Region ID and date)	
Person 1	
Person 2	

DONOR QUESTIONNAIRE – Faeces donor (FMT Start)
All health information will be treated confidentially.

Full name: _____ **Personal ID number:** _____

Since your last visit:	No	Yes
Do you feel completely healthy?	<input type="checkbox"/>	<input type="checkbox"/>
Within the last 6 months, have you been at risk of contracting blood-borne or sexually transmitted diseases (e.g., engaged in sexual risk behaviour, received a tattoo/piercing/acupuncture, shared a syringe or needle with others, had a blood transfusion, or been exposed to HIV infection or infectious hepatitis)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medication daily or periodically?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you been ill or examined by a doctor since your last stool donation?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your household been ill since your last stool donation?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your household been diagnosed with multi-resistant bacteria (e.g., MRSA or CPO)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you travelled outside Denmark since your last donation?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed changes in your stool since your last stool donation?.....	<input type="checkbox"/>	<input type="checkbox"/>
Based on the Bristol Stool Scale: assess today's stool (/, 1-7).....	_____	_____
Time of toilet visit (date and time).....	_____	_____
I confirm that the stool is mine.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any additional comments?.....	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

_____ Date _____ Donor Signature

Reserved for Blood and Tissue Centre Midt

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