

Donating your child's cord blood is truly a *Life Saving* endeavor. To ensure the success of the donation, please read this information carefully. If you have any questions, please call our toll-free number (800) 869-8608. For additional information about the cord blood donation program or if you wish to proceed with donating your child's cord blood, visit our website [www.cordforlife.com](http://www.cordforlife.com). Registration forms are available on the web or you may complete the attached forms and forward to the address listed at the bottom of this page.

## IMPORTANT INFORMATION BEFORE YOU PROCEED

- **You must be less than 34<sup>th</sup> week gestation to begin the application process**
- **You must be 18 years of age or older in order to donate your baby's cord blood**
- **We cannot accept cord blood donations from:**
  - **Multiple births (Acceptable for Private Storage-ONLY)**
  - **If you and your physician have chosen to delay the clamping of the cord after your child's birth (Acceptable for Private Storage-ONLY)**
- **Because Cord For Life is a privately funded company, we are limited to the amount of donations we can accept monthly**
- **Due to circumstances outside of Cord For Life control we are unable to accept cord blood units for public donation that were collected between Friday 3:00PM (EST) through Sunday 3:00PM (EST)**

Speak with your doctor or midwife about donating the cord blood. Find out if the doctor is willing to perform this collection and if there will be any collection fees involved. Cord For Life does not charge collection fees, but some doctors may charge for this service. We suggest that you do not donate if you are going to be charged a fee. Cord For Life cannot reimburse you or your doctor/midwife for cord blood collection fees.

### ABOUT THE ATTACHED FORMS:

The intent of the attached documents is to ensure the following:

1. You and your physician have a thorough understanding of the cord blood donation program.
2. The cord blood is collected properly and safely.
3. The quality of the cord blood product collected.

Please read all the documents thoroughly and complete all the requested documentation. **Blanks or omissions can result in the unit not meeting regulatory standards (FDA, AABB, NMDP) preventing Cord For Life from making the unit available for a transplant recipient.** Use only **BLACK** or **BLUE** ink when completing the forms. It is important that you use only your **legal name\*** consistently on each document. Below is a description of the attached forms:

- **Informed Consent for Cord Blood Medical Research, Form B.1-7**

This form explains the National Marrow Donor Program (NMDP) protocol. Cord Blood stem cell transplantation is being investigated/studied by the NMDP, as such, it is important that you "the donor" understand the details of this program and how information regarding your donation will be utilized in this investigation.

- **Cord For Life Donor Information and Health Questionnaire, Form B.1-1**

**Donor Information:** The donor information section provides demographic data for yourself, the baby's father and your physician. In addition, it contains a "Baby's Ethnicity" section. This information is used to assist in the NMDP investigation and will not be used, in any manner, to prevent your unit from being placed on the registry. **IMPORTANT:** Your signature at the bottom of this page is **mandatory**. Remember to sign using only your legal name\* as written at the top of the form.

**Health Questionnaire:** A thorough health history is an important part of ensuring the safety and quality of the cord blood. These questions may seem overwhelming, but they are a necessity. Any potential risk to a transplant recipient must be investigated. If you are unsure, contact a Cord For Life representative, they will assist you with any questions or concerns. Many of the items are not a reason for deferral but do require further information or clarification before acceptability is assigned. **IMPORTANT:** If you consider yourself to be at risk as described in the donation information, **please do not donate**. The standards and regulations set forth for all blood banks prevent us from accepting or using any cord blood from an at-risk donor.

- **Donation Informed Consent, Release-Hospital Birthing Center and The Inform Consent for HIV Test, Form B.1-9**

These are agreements between yourself, your physician and Cord For Life for the cord blood donation and information about HIV and consent for HIV testing. The **physician must sign** where indicated to allow Cord For Life to perform the required disease testing. Even if you have had previous prenatal testing done, we are required to test your blood for infectious diseases from a sample collected within 48 hours of your baby's birth. Tubes for the collection of your blood are included in the kit, and your blood will be drawn around the time of delivery by the hospital or birth center staff. **IMPORTANT:** The results of your blood tests are confidential. You and your physician /midwife will be notified of any abnormal results via certified mail. It may be necessary to report certain positive test results to your local health department.

- **Physician/Midwife Training Material Request for CB Collection, Form C.1-4**

To ensure the cord blood is collected in a manner that results in the best possible product, Cord For Life requires the physician/midwife read and complete this form. Cord For Life offers training material options, at no cost, to the physician/midwife on request.

We thoroughly review all of your documentation on receipt. You will be contacted, by email, to review the information and obtain any additional information, if needed. If accepted as a donor, we will issue you a cord blood collection kit, which includes collection instructions for your physician or nurse/midwife. (Collection kits will be shipped to the address you provided unless we are notified otherwise).

Regulations require confirmation of your health status within **48 hours of delivery**. Included in the kit will be a copy of your completed Health Questionnaire (B.1-1) and a Verification Form (B.1-5). Form B.1-5 must be completed the day of delivery prior to forwarding the cord blood unit to Cord For Life. Update any changes to your health status between the time you filled out your original forms and the time you deliver. Please keep it with the kit so that you can fill out the verification card at that time and send it back with the cord blood.

Bring the collection kit to your hospital or birthing center when you go into labor. Your doctor or hospital's delivery staff will collect the blood remaining in the umbilical cord and placenta after your baby is delivered. Your blood will also be drawn during labor or after delivery.

Notify Cord For Life **when in active labor and after the birth of your baby**, day or night. It is **your responsibility to ensure that we are notified within two hours after the collection of the cord blood.**

\*Full First Name, Middle Initial or Full Middle Name, Last Name



A COLLECTION PARTNER OF THE CORD FOR LIFE® FOUNDATION

## DONOR INFORMATION AND HEALTH HISTORY

|                           |  |            |      |      |                   |          |
|---------------------------|--|------------|------|------|-------------------|----------|
| MOTHER'S <u>LAST</u> NAME |  | FIRST NAME |      | M.I. | LAST 4 SS# DIGITS |          |
| BEST CONTACT PHONE:       |  | EMAIL      |      |      | MOTHER'S DOB:     |          |
| ADDRESS                   |  |            | CITY |      | STATE             | ZIP CODE |

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|                           |  |            |      |      |                             |          |
|---------------------------|--|------------|------|------|-----------------------------|----------|
| FATHER'S <u>LAST</u> NAME |  | FIRST NAME |      | M.I. | LAST 4 SS# DIGITS(OPTIONAL) |          |
| BEST CONTACT PHONE:       |  | EMAIL      |      |      | FATHERS DOB:                |          |
| ADDRESS                   |  |            | CITY |      | STATE                       | ZIP CODE |

**BABY'S DUE DATE:**

|                           |  |       |                |
|---------------------------|--|-------|----------------|
| DELIVERY PHYSICIAN'S NAME |  | PHONE |                |
| CLINIC NAME               |  |       |                |
| DELIVERY HOSPITAL NAME    |  | PHONE |                |
| HOSPITAL ADDRESS          |  | CITY  | STATE ZIP CODE |

### BABY'S RACE AND ETHNICITY INFORMATION

Since certain HLA Types may be more common in each ethnic group; the information below will help in selecting a cord blood unit for transplant.

**Baby's Ethnicity: Response is required, please check one.** ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

**Baby's Race: Response is required.** Of which group(s) is your baby a member? (Select all that apply.)

#### American Indian or Alaska Native

|                          |                                                   |
|--------------------------|---------------------------------------------------|
| <input type="checkbox"/> | Alaska Native or Aleut (ALANAM)                   |
| <input type="checkbox"/> | North American Indian (AMIND)                     |
| <input type="checkbox"/> | American Indian South or Central American (AMIND) |
| <input type="checkbox"/> | Caribbean Indian (AMIND)                          |

#### Black or African American

|                          |                                         |
|--------------------------|-----------------------------------------|
| <input type="checkbox"/> | African (AFB)                           |
| <input type="checkbox"/> | African American (AAFA)                 |
| <input type="checkbox"/> | Black Caribbean (CARB)                  |
| <input type="checkbox"/> | Black South or Central American (SCAMB) |

#### Asian

|                          |                                |
|--------------------------|--------------------------------|
| <input type="checkbox"/> | Chinese (NCHI)                 |
| <input type="checkbox"/> | Filipino (Philipino) (FILI)    |
| <input type="checkbox"/> | Japanese (JAPI)                |
| <input type="checkbox"/> | Korean (KORI)                  |
| <input type="checkbox"/> | South Asian (SCSEAI)           |
| <input type="checkbox"/> | Vietnamese (SCSEAI)            |
| <input type="checkbox"/> | Other Southeast Asian (SCSEAI) |

#### Native Hawaiian or Other Pacific Islander

|                          |                              |
|--------------------------|------------------------------|
| <input type="checkbox"/> | Guamanian (OPI)              |
| <input type="checkbox"/> | Hawaiian (HAWI)              |
| <input type="checkbox"/> | Samoa (OPI)                  |
| <input type="checkbox"/> | Other Pacific Islander (OPI) |

#### White

|                          |                               |
|--------------------------|-------------------------------|
| <input type="checkbox"/> | Eastern European (CAU)        |
| <input type="checkbox"/> | Mediterranean (CAU)           |
| <input type="checkbox"/> | Middle Eastern (MENAF)        |
| <input type="checkbox"/> | North Coast of Africa (MENAF) |
| <input type="checkbox"/> | North American (CAU)          |

|                          |                                       |
|--------------------------|---------------------------------------|
| <input type="checkbox"/> | Northern European (CAU)               |
| <input type="checkbox"/> | Western European (CAU)                |
| <input type="checkbox"/> | White Caribbean (CAU)                 |
| <input type="checkbox"/> | White South or Central American (CAU) |
| <input type="checkbox"/> | Other White (CAU)                     |

Please read the following Health Questionnaire **carefully**. You may contact Cord For Life, Inc. (CFL), if you need help understanding any of the questions, please call: 1-800-869-8608 outside of the Orlando area, or 407-834-8333 in the Orlando area.

Completion of all the requested information on the health questionnaire is required before a cord blood unit can be eligible for transplant. This is the only opportunity the cord blood center has to gather this important information from you. **An incomplete questionnaire will result in disqualification.** The questionnaire should be filled out privately by the expectant mother only, or in a private interview by an approved screener. Your answers to these questions are confidential. Cord For Life, Inc. (CFL) Notice of Privacy Practices are available upon request.

If after being accepted into this program or after your baby's cord blood is collected, you learn of a reason which would exclude you from donating or feel that it should not be transfused to a patient, please call Cord For Life, Inc. (CFL). You will not be penalized from withdrawing from the program at any time.

My signature below confirms that the information provided on Pages 1-8 of Form, B.1-1 is true and accurate to the best of my knowledge.

**MOTHER'S SIGNATURE::** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: \_\_\_\_\_

MOTHER'S DOB: \_\_\_\_\_

### CORD BLOOD DONOR QUESTIONS

Please **read carefully** and **answer each** of the following questions **individually** "Y" for "YES" or "N" for "NO".  
Please provide details for all "Y" responses, including dates, where requested.

|    |                                                                                                                                                                                                                                                                                                                                                            |                            |                            |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| 1  | Have you ever donated or attempted to donate cord blood using your current or a different name to Cryobanks International, Lifeforce Cryobank Sciences, Inc. (LFC) or Cord For Life, Inc. (CFL)? Details: _____                                                                                                                                            | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 2  | Have you, for any reason, been deferred or refused as a blood or cord blood donor, or been told not to donate blood or cord blood? <b>If yes</b> , why? _____                                                                                                                                                                                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 3  | Have you taken any of the following medications (check all that apply):<br>a. <input type="checkbox"/> <b>Insulin from cows (bovine or beef insulin) since 1980?</b><br>b. <input type="checkbox"/> <b>Growth hormone from human pituitary glands ever?</b>                                                                                                | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 4  | <b>In the past 8 weeks</b> , have you had any shots or vaccinations?<br><b>If yes</b> , details: _____                                                                                                                                                                                                                                                     | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 5  | Have you received a Covid-19 vaccination?                                                                                                                                                                                                                                                                                                                  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 6  | <b>In the past 12 weeks</b> , have you had contact with someone who has received the smallpox vaccine? (Examples of contact include physical intimacy, touching the vaccination site, touching the bandages or covering the vaccination site, or handling bedding or clothing that had been in contact with an unbandaged vaccination site) Details: _____ | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 7  | <b>In the past 4 months</b> , have you experienced <b>TWO (2)</b> or more of the following: a fever (>100.5°F or 38.6°C), headache, muscle weakness, skin rash on trunk of the body, swollen lymph glands? <b>If yes</b> , which symptoms and when? Details: _____                                                                                         | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 8  | Have you ever had any type of cancer, including leukemia?<br><b>If yes</b> , details: _____                                                                                                                                                                                                                                                                | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 9  | During your pregnancy, have you been diagnosed with West Nile Virus or had a positive test for West Nile Virus?                                                                                                                                                                                                                                            | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 10 | Have you ever had a past diagnosis of clinical, symptomatic viral hepatitis after age 11? <b>If yes</b> , details, with dates: _____                                                                                                                                                                                                                       | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 11 | Have you ever had a parasitic blood disease such as Leishmaniasis, Chagas disease or Babesiosis or any positive test for Chagas or T. cruzi, including screening tests?                                                                                                                                                                                    | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 12 | Have you ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), Variant CJD, dementia, degenerative or demyelinating disease of the central nervous system, or other neurological disease where the cause is unknown?                                                                                                                                   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 13 | Have any of your blood relatives ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), or have you been told that your family has an increased risk for CJD?                                                                                                                                                                                           | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 14 | Have you received a dura mater (brain covering) graft?                                                                                                                                                                                                                                                                                                     | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 15 | Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an <b>animal</b> ? Details: _____                                                                                                                                                                                             | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 16 | Have you ever lived with or had sexual contact with anyone who had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an <b>animal</b> ?<br><b>If yes</b> , details: _____                                                                                                                         | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 17 | <b>In the past 3 years</b> , have you had malaria?<br><b>If yes</b> , details: _____                                                                                                                                                                                                                                                                       | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 18 | <b>In the past 3 years</b> , have you been outside the United States or Canada?<br>Where: _____<br>When: _____<br>How Long: _____                                                                                                                                                                                                                          | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 19 | <b>In the past 12 months</b> , have you had a blood transfusion? Details: _____                                                                                                                                                                                                                                                                            | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 20 | <b>In the past 12 months</b> , have you had a transplant or tissue graft from someone other than yourself, such as organ, bone marrow, stem cell, cornea, bone, skin or other tissue?                                                                                                                                                                      | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 21 | <b>In the past 12 months</b> , have you had a tattoo or piercing (ear, skin or body)? <b>If yes</b> , please indicate type and answer question 22. <b>If no</b> , skip to question 23.<br>Type: <input type="checkbox"/> <b>Tattoo</b> <input type="checkbox"/> <b>Piercing</b> , details: _____                                                           | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 22 | <b>If yes</b> , were shared or non-sterile instruments, needles, or inks used for the tattoo or piercing?                                                                                                                                                                                                                                                  | Y <input type="checkbox"/> | N <input type="checkbox"/> |

## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: \_\_\_\_\_

MOTHER'S DOB: \_\_\_\_\_

|    |                                                                                                                                                                                                                                                                           |                            |                            |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| 23 | In the past 12 months, have you had an accidental needle stick, or have you come into contact with someone else's blood through an open wound (for example, a cut or sore), non-intact skin, or mucous membrane (for example, into your eye, mouth, etc.)? Details: _____ | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 24 | Any history of drug or alcohol abuse? <b>If Yes</b> , please describe _____                                                                                                                                                                                               | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 25 | In the past 12 months, have you had or been treated for a sexually transmitted disease, including syphilis? <b>If yes</b> , details with dates: _____                                                                                                                     | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 26 | In the past 12 months have you given money, drugs, or other payment to anyone to have sex with you?                                                                                                                                                                       | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 27 | In the past 12 months have you had sex with anyone who has taken money, drugs, or other payment in exchange for sex in the <b>past 5 years</b> ?                                                                                                                          | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 28 | In the past 12 months, have you had sexual contact or lived with a person who has active or chronic viral hepatitis B or Hepatitis C?                                                                                                                                     | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 29 | In the past 12 months, have you had sex, even once, with anyone who has used a needle to take drugs, steroids, or anything else not prescribed by a doctor in the <b>past 5 years</b> ?                                                                                   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 30 | In the past 12 months, have you had sex with a male who has had sex with another male, even once, in the <b>past 5 years</b> ?                                                                                                                                            | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 31 | In the past 12 months, have you had sex, even once, with anyone who has HIV/AIDS or had a positive test for the AIDS virus?                                                                                                                                               | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 32 | In the past 12 months, have you been in juvenile detention, lockup, jail or prison for more than 72 <b>continuous</b> hours?                                                                                                                                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 33 | In the past 5 years have you received money, drugs, or other payment for sex?                                                                                                                                                                                             | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 34 | In the past 5 years, have you used a needle, even once, to take drugs, steroids or anything else not prescribed for you by a doctor?                                                                                                                                      | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 35 | Do you have AIDS, or have you ever tested positive for HIV (including screening tests)?                                                                                                                                                                                   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 36 | <b>Do you have any of the following:</b>                                                                                                                                                                                                                                  |                            |                            |
|    | A) Unexplained night sweats?                                                                                                                                                                                                                                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | B) Unexplained blue or purple spots on or under the skin or mucous membranes?                                                                                                                                                                                             | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | C) Unexplained weight loss?                                                                                                                                                                                                                                               | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | D) Unexplained persistent diarrhea?                                                                                                                                                                                                                                       | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | E) Unexplained cough or shortness of breath?                                                                                                                                                                                                                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | F) Unexplained temperature higher than 100.5°F (38.6°C) for more than 10 days?                                                                                                                                                                                            | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | G) Unexplained persistent white spots or sores in the mouth?                                                                                                                                                                                                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | H) Lumps in your neck, armpits, or groin lasting longer than one month?                                                                                                                                                                                                   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | I) Any infection during your pregnancy?                                                                                                                                                                                                                                   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 37 | Have you ever tested positive for HTLV-Human T-cell Lymphotropic Virus (including screening tests) or had unexplained paraparesis (partial paralysis affecting the lower limbs)?                                                                                          | Y <input type="checkbox"/> | N <input type="checkbox"/> |

|    |                                                                                                                                                               |                            |                            |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| 38 | Do you understand that if you have the AIDS virus, <b><u>you can give it to someone else</u></b> even though you may feel well and have a negative AIDS test? | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|

## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: \_\_\_\_\_

MOTHER'S DOB: \_\_\_\_\_

### FOR USE WITH QUESTIONS #39 – 42 – COUNTRIES DEFINED AS EUROPE

|                                                                                              |                                                                                                 |                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ALBANIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>GREECE</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                | <b>ROMANIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                                               |
| <b>AUSTRIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>HUNGARY</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____               | <b>SLOVAK REPUBLIC</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                                       |
| <b>BELGIUM</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>IRELAND (REPUBLIC OF)</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____ | <b>SLOVENIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                                              |
| <b>BOSNIA-HERZEGOVINA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____ | <b>ITALY</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                 | <b>SPAIN</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                                                 |
| <b>BULGARIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____           | <b>LIECHTENSTEIN</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____         | <b>SWEDEN</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                                                |
| <b>CROATIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>LUXEMBOURG</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>SWITZERLAND</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                                           |
| <b>CZECH REPUBLIC</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____     | <b>MACEDONIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____             | <b>UNITED KINGDOM (UK)</b> includes England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands Gibraltar & Falkland Islands<br>_____ Travel _____ Resident.<br>Date(s): _____<br>Total Time _____ |
| <b>DENMARK</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>NETHERLANDS (HOLLAND)</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____ |                                                                                                                                                                                                                 |
| <b>FINLAND</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>NORWAY</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                | <b>YUGOSLAVIA (FEDERAL REPUBLIC OF)</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                      |
| <b>FRANCE</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____             | <b>POLAND</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                | <b>KOSOVO, MONTENEGRO, SERBIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                                                                                                            |
| <b>GERMANY</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____            | <b>PORTUGAL</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____              |                                                                                                                                                                                                                 |

|           |                                                                                                                                                                                                                                                                                                                                                              |                            |                            |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| <b>39</b> | <b>Since 1980</b> , have you ever lived in or traveled to Europe? ( <i>refer to chart above</i> ) <b>If no</b> , skip to question <b>43</b> .<br>a) Use the chart above and place a check in all the appropriate box(es) above to identify the country(ies), reason, date(s) and total time that apply.<br>b) Answer questions <b>40</b> through <b>42</b> . | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | <b>40. From 1980 through 1996</b> , did you spend time that adds up to 3 months or more in the United Kingdom ( <i>refer to chart above</i> )?                                                                                                                                                                                                               | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | <b>41. Since 1980</b> , have you received a transfusion of blood or blood components while in the UK or France?                                                                                                                                                                                                                                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | <b>42. Since 1980</b> , have you spent time that <b>adds up to 5 years or more</b> in Europe ( <i>refer to chart above</i> ), including time spent in the UK between 1980 and 1996?                                                                                                                                                                          | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>43</b> | <b>From 1980 through 1996</b> , were you a member of the U.S. military, a civilian military employee, or a dependent of a member of the U.S. military?                                                                                                                                                                                                       | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>44</b> | <b>From 1980 through 1990</b> , did you spend a <b>total of 6 months or more</b> associated with a military base in any of the following countries: United Kingdom, Belgium, Netherlands or Germany?                                                                                                                                                         | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>45</b> | <b>From 1980 through 1996</b> , did you spend a <b>total of 6 months or more</b> associated with a military base in any of the following countries: Spain, Portugal, Turkey, Italy or Greece?                                                                                                                                                                | Y <input type="checkbox"/> | N <input type="checkbox"/> |

## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: \_\_\_\_\_

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### FOR USE WITH QUESTIONS 46-48: AFRICAN COUNTRIES

|                                                                                                    |                                                                                             |                                                                                   |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>BENIN</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                    | <b>EQUATORIAL GUINEA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____ | <b>SENEGAL</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____ |
| <b>CAMEROON</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                 | <b>GABON</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____             | <b>TOGO</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____    |
| <b>CENTRAL AFRICAN REPUBLIC</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____ | <b>KENYA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____             | <b>ZAMBIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____  |
| <b>CHAD</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                     | <b>NIGER</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____             |                                                                                   |
| <b>CONGO</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____                    | <b>NIGERIA</b> _____ Travel _____ Resident<br>Date(s): _____<br>Total Time: _____           |                                                                                   |

|           |                                                                                                                                                                                                                                                                                                                                                                     |                            |                            |
|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| <b>46</b> | Since 1977, were you born in, have you lived in, or have you traveled to any African country listed above? <b>If yes</b> , answer question 47. <b>If no</b> , skip to question 48.<br>a) Use the chart above and place a check in all the appropriate box(es) above to identify the country(ies), reason, date(s) and total time that apply.                        | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | 47. While in one of the African countries listed above, did you receive a blood transfusion or any other medical treatment with a product made from blood?                                                                                                                                                                                                          | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>48</b> | Have you had sexual contact with anyone who was born in or lived in any African country listed above <b>since 1977</b> ?                                                                                                                                                                                                                                            | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>49</b> | Any history of acute respiratory disease? <b>If Yes</b> , please describe _____                                                                                                                                                                                                                                                                                     | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>50</b> | Any active tuberculosis disease or history of tuberculosis therapy? <b>If Yes</b> , please describe _____                                                                                                                                                                                                                                                           | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | <b>Evaluation of TB risk: A-E must be complete</b>                                                                                                                                                                                                                                                                                                                  |                            |                            |
|           | A) Have you ever had a positive test for tuberculosis (TB) infection or a medical diagnosis of TB disease, TB infection, or latent tuberculosis infection (LTBI)?                                                                                                                                                                                                   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | B) Have you ever lived with a person who has TB or been in close contact with a person with TB? <b>If Yes</b> , answer F.                                                                                                                                                                                                                                           | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | C) Have you ever lived or worked in a high-risk congregate setting? (e.g. jail, prison, correctional facility, long-term care facility, homeless shelter, etc.) <b>If Yes</b> , answer F.                                                                                                                                                                           | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>51</b> | D) Were you born in, have you lived in, or have you ever traveled to any of the following areas of the world where TB is common? [e.g. Latin America, the Caribbean, Africa, Asian Eastern Europe (Belarus, Bulgaria, Czech Republic, Hungary, Moldova, Poland, Romania, Slovakia, and Ukraine), and Russia] <b>If Yes</b> , answer F.                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | E) Do you have impaired immunity (e.g. diabetes, chronic kidney disease, or taking a medication that impairs your immune system)? <b>If Yes</b> , answer F.                                                                                                                                                                                                         | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | F) If yes to questions 51 B-E above, do you report any of the following symptoms consistent with tuberculosis?<br>Symptoms: Cough lasting 3 weeks or longer, chest pain, coughing up blood or sputum, weakness or fatigue, unexplained weight loss or muscle loss, loss of appetite, fever chills or night sweats, generalized swollen lymph nodes, blood in urine, | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>52</b> | a.) Were you and/or the baby's father adopted at early childhood?                                                                                                                                                                                                                                                                                                   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | b.) If yes, is a family medical history available for you and/or the baby's father?                                                                                                                                                                                                                                                                                 | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>53</b> | Are you and the baby's father related, except by marriage? (e.g., first cousins)                                                                                                                                                                                                                                                                                    | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | A.) Did this pregnancy use either a donor egg or donor sperm?                                                                                                                                                                                                                                                                                                       | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| <b>54</b> | B.) If yes, is a family medical history questionnaire available for the egg or sperm donor? (please attach copy)                                                                                                                                                                                                                                                    | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|           | Name of the Clinic: _____                                                                                                                                                                                                                                                                                                                                           |                            |                            |



## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: \_\_\_\_\_

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|    |                                                                                                                                                            |                            |                            |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| 55 | Have you ever had an abnormal result from a prenatal test (e.g., amniocentesis, blood test, and ultrasound)? If yes, answer the following questions (A-C). | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | A) Which test was abnormal? _____                                                                                                                          |                            |                            |
|    | B) What was the abnormal test result? _____                                                                                                                |                            |                            |
|    | C) Was a diagnosis made? Specify diagnosis: _____                                                                                                          |                            |                            |
| 56 | Have you had any children who died within the first 10 years of life?                                                                                      | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | If yes, what was the cause? _____                                                                                                                          |                            |                            |
| 57 | Have you ever had a stillborn child?                                                                                                                       | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | If yes, what was the cause? _____                                                                                                                          |                            |                            |
| 58 | Have you had a medical diagnosis of ZIKV (Zika) infection at any point during your pregnancy?                                                              | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 59 | Have you resided in, or travel to, an area with active ZIKV (Zika) transmission at any point during your pregnancy?                                        | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 60 | Have you had sex during your pregnancy with a male or female who is known to have:                                                                         | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|    | a) A medical diagnosis of ZIKV (Zika) within the six months prior to that contact.                                                                         |                            |                            |
|    | b) Resided in, or traveled to, an area with active ZIKV (Zika) transmission within the six months prior to that contact.                                   |                            |                            |

### FAMILY MEDICAL HISTORY

For the following questions please use the following codes to describe the relationship between the baby and a family member with a disease:  
**Family Relationship Codes:** BM Baby's Mother BGP Baby's Grandparent BMS Baby's Mother Sibling  
 BF Baby's Father BS Baby's sibling BFS Baby's Father's Sibling  
 (Parents' sibling (BMS and BFS) refer to the baby's aunts and uncles by blood and does not include aunts and uncles who are in-laws of the parents.)

|    |                                                                         |                            |                            |                          |                          |                          |                             |                          |                          |
|----|-------------------------------------------------------------------------|----------------------------|----------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| 61 | Cancer or Leukemia?                                                     | Y <input type="checkbox"/> | N <input type="checkbox"/> |                          |                          |                          |                             |                          |                          |
|    | If yes, please specify all that apply. If no, proceed to next question. |                            |                            | BM                       | BF                       | BS                       | IMMEDIATE<br>FAMILY<br>ONLY |                          |                          |
|    | A) Brain or other nervous system cancer                                 | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | B) Bone or joint cancer                                                 | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | C) Kidney (including renal pelvic) cancer                               | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | D) Thyroid Cancer                                                       | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | E) Hodgkin's Lymphoma                                                   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | F) Non-Hodgkin's Lymphoma                                               | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | G) Acute or chronic myelogenous/myeloid leukemia                        | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | H) Acute or chronic lymphocytic/lymphoblastic leukemia                  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | I) Skin Cancer                                                          | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> |                          |                          |                             |                          |                          |
|    | J) Other cancer/leukemia                                                |                            |                            |                          |                          |                          |                             |                          |                          |
|    | Specify Type: _____                                                     |                            |                            |                          |                          |                          |                             |                          |                          |
|    | Specify Type: _____                                                     |                            |                            |                          |                          |                          |                             |                          |                          |
| 62 | Red Blood Cell                                                          | Y <input type="checkbox"/> | N <input type="checkbox"/> |                          |                          |                          |                             |                          |                          |
|    | If yes, please specify all that apply. If no, proceed to next question. |                            |                            | BM                       | BF                       | BS                       | BGP                         | BMS                      | BFS                      |
|    | A) Diamond-Blackfan Syndrome                                            | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/> |
|    | B) Elliptocytosis                                                       | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/> |
|    | C) G6PD or other red cell enzyme deficiency                             | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/> |
|    | D) Spherocytosis                                                        | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/> |

|    |                           |                            |                            |  |  |  |  |  |  |
|----|---------------------------|----------------------------|----------------------------|--|--|--|--|--|--|
| 63 | White Blood Cell Disease? | Y <input type="checkbox"/> | N <input type="checkbox"/> |  |  |  |  |  |  |
|----|---------------------------|----------------------------|----------------------------|--|--|--|--|--|--|

## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: \_\_\_\_\_

MOTHER'S DOB: \_\_\_\_\_

|                             |                                                                                              |  |                                   |                                   |                          |                          |                          |                          |                          |
|-----------------------------|----------------------------------------------------------------------------------------------|--|-----------------------------------|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>64</b>                   | <b>If yes, please specify all that apply. If no, proceed to next question.</b>               |  |                                   | <b>BM</b>                         | <b>BF</b>                | <b>BS</b>                | <b>BGP</b>               | <b>BMS</b>               | <b>BFS</b>               |
|                             | A) Chronic Granulomatous Disease                                                             |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | B) Kostmann Syndrome.                                                                        |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | C) Schwachman-Diamond Syndrome                                                               |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | D) Leukocyte Adhesion Deficiency (LAD)                                                       |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Immune Deficiencies?</b> |                                                                                              |  | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> |                          |                          |                          |                          |                          |
| <b>64</b>                   | <b>If yes, please specify all that apply. If no, proceed to next question.</b>               |  |                                   | <b>BM</b>                         | <b>BF</b>                | <b>BS</b>                | <b>BGP</b>               | <b>BMS</b>               | <b>BFS</b>               |
|                             | A) ADA or PNP Deficiency                                                                     |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | B) Combined Immunodeficiency Syndrome (CID), Common Variable Immunodeficiency Disease (CVID) |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | C) DiGeorge Syndrome                                                                         |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | D) Hereditary Hemophagocytic Lymphohistiocytosis (HLH) including FEL                         |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | E) Hypoglobulinemia                                                                          |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | F) Nezeloff Syndrome                                                                         |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | G) Severe Combined Immunodeficiency                                                          |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                             | H) Wiskott-Aldrich Syndrome                                                                  |  |                                   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|                            |                                                                                |  |                                   |                                   |                          |                          |                          |                          |                          |                          |
|----------------------------|--------------------------------------------------------------------------------|--|-----------------------------------|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>65</b>                  | <b>Platelet Disease?</b>                                                       |  | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> |                          |                          |                          |                          |                          |                          |
|                            | <b>If yes, please specify all that apply. If no, proceed to next question</b>  |  |                                   |                                   | <b>BM</b>                | <b>BF</b>                | <b>BS</b>                | <b>BGP</b>               | <b>BMS</b>               | <b>BFS</b>               |
|                            | A) Amegakaryocytic Thrombocytopenia                                            |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | B) Glanzmann Thrombasthenia                                                    |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | C) Hereditary Thrombocytopenia                                                 |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | D) Platelet Storage Pool Disease                                               |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | E) Thrombocytopenia with absent radii (TAR)                                    |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | F) Ataxia-Telangiectasia                                                       |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>66</b>                  | <b>Other blood disorder or problem</b>                                         |  | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | Specify disease: _____                                                         |  |                                   |                                   |                          |                          |                          |                          |                          |                          |
| <b>Hemoglobin Problems</b> |                                                                                |  |                                   |                                   | <b>BM</b>                | <b>BF</b>                | <b>BS</b>                | <b>BGP</b>               | <b>BMS</b>               | <b>BFS</b>               |
| <b>67</b>                  | <b>Sickle cell disease, such as sickle-cell anemia or sickle thalassemia?</b>  |  | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | Specify disease: _____                                                         |  |                                   |                                   |                          |                          |                          |                          |                          |                          |
| <b>68</b>                  | <b>Thalassemia, such as alpha thalassemia or beta-thalassemia?</b>             |  | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>69</b>                  | <b>Metabolic/Storage Disease?</b>                                              |  | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> |                          |                          |                          |                          |                          |                          |
|                            | <b>If yes, please specify all that apply. If no, proceed to next question.</b> |  |                                   |                                   | <b>BM</b>                | <b>BF</b>                | <b>BS</b>                | <b>BGP</b>               | <b>BMS</b>               | <b>BFS</b>               |
|                            | A) Hurler Syndrome (MPS I)                                                     |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | B) Hurler-Scheie Syndrome (MPS I H-S)                                          |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | C) Hunter Syndrome (MPS II)                                                    |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | D) Sanfilippo Syndrome (MPS III)                                               |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | E) Morquio Syndrome (MPS IV)                                                   |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | F) Maroteaux-Lamy Syndrome (MPS VI)                                            |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | G) Sly Syndrome (MPS VII)                                                      |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | H) I-cell disease                                                              |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | I) Globoid Leukodystrophy (Krabbe Disease)                                     |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | J) Metachromatic Leukodystrophy (MLD)                                          |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                            | K) Adrenoleukodystrophy (ALD)                                                  |  |                                   |                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: \_\_\_\_\_

MOTHER'S DOB: \_\_\_\_\_

|                                                                                                                           |                                                                                                                                    |                          |                          |                          |                          |                          |                          |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                                                                                                           | <b>L)</b> Sandhoff Disease                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
|                                                                                                                           | <b>M)</b> Tay-Sachs Disease                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
|                                                                                                                           | <b>N)</b> Gaucher Disease                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
|                                                                                                                           | <b>O)</b> Niemann Pick-Disease                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
|                                                                                                                           | <b>P)</b> Porphyria                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
|                                                                                                                           | <b>Q)</b> Other or unknown metabolic/storage disease, Details: _____                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| <b>Acquired Immune System Disorders</b>                                                                                   |                                                                                                                                    | <b>BM</b>                | <b>BF</b>                | <b>BS</b>                | IMMEDIATE FAMILY ONLY    |                          |                          |                          |                          |
| <b>70</b>                                                                                                                 | <b>HIV/AIDS?</b>                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |
|                                                                                                                           | <b>Severe autoimmune disorder?</b>                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |
|                                                                                                                           | <i>If yes, please specify all that apply including providing the other requested information. If no, proceed to next question.</i> | <b>BM</b>                | <b>BF</b>                | <b>BS</b>                |                          |                          |                          |                          |                          |
| <b>71</b>                                                                                                                 | <b>A)</b> Crohn's Disease or Ulcerative Colitis                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |
|                                                                                                                           | <b>B)</b> Lupus                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |
|                                                                                                                           | <b>C)</b> Multiple Sclerosis (MS)                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |
|                                                                                                                           | <b>D)</b> Rheumatoid Arthritis                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |
| Diagnosis Date: _____<br>Currently under MD care? Describe: _____<br>Are you currently taking any medication? Name: _____ |                                                                                                                                    |                          |                          |                          |                          |                          |                          |                          |                          |
| <b>72</b>                                                                                                                 | Any diagnosis of other or unknown immune system disorder?                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <b>BM</b>                |                          |                          |                          | <b>BF</b>                | <b>BS</b>                |
|                                                                                                                           | Specify Disorder: _____                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|                                                                                                                           |                                                                                                                                    | <b>BM</b>                | <b>BF</b>                | <b>BS</b>                | <b>BGP</b>               | <b>BMS</b>               | <b>BFS</b>               |                          |                          |
| <b>73</b>                                                                                                                 | Required Chronic Blood Transfusions?                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| <b>74</b>                                                                                                                 | Been told you or your family member(s) have hemolytic anemia?                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| <b>75</b>                                                                                                                 | Had spleen removed to treat a blood disorder?                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| <b>76</b>                                                                                                                 | Had gallbladder removed before the age of 30?                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| <b>77</b>                                                                                                                 | Had Creutzfeldt-Jakob disease (CJD)?                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| <b>78</b>                                                                                                                 | Other serious or life-threatening diseases affecting the family?                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <b>BM</b>                | <b>BF</b>                | <b>BS</b>                | <b>BGP</b>               | <b>BMS</b>               | <b>BFS</b>               |
|                                                                                                                           | <i>If yes, list affected family member(s) and type of disease</i>                                                                  |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                           | Specify Type: _____                                                                                                                |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                           | Specify Type: _____                                                                                                                |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                           | Specify Type: _____                                                                                                                |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>79</b>                                                                                                                 | In answering these questions, have you answered for both your family and the baby's father's family?                               | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |                          |

### Addendum A: Viral Infection Risk Assessment

|           |                                                                                                                                                                                                    |                          |                          |
|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <b>80</b> | <b>A)</b> In the past <b>6 weeks</b> , have you had any of the following symptoms: fever, rash, severe headache, chills, muscle aches, and/or joint pains? <i>If yes, which symptoms and when?</i> | <input type="checkbox"/> | <input type="checkbox"/> |
|           | <b>B)</b> If yes to 80a, do you have any ongoing concerns related to these symptoms? <i>If yes, please describe:</i>                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
|           | <b>C)</b> If yes to 80a, have these symptoms resolved? <i>If yes, when did they resolve?</i>                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>81</b> | In the past <b>6 weeks</b> , have you been diagnosed with a viral illness such as Oropouche or Mpox? <i>If yes, please describe:</i>                                                               | <input type="checkbox"/> | <input type="checkbox"/> |

## HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# : \_\_\_\_\_

MOTHER'S DOB: \_\_\_\_\_

|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |                            |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| <b>82</b> | <p><b>In the past 12 months</b>, were you exposed to rabies or did you receive bites from bats, skunks, dogs, or unknown animals that had rabies, which were suspected of having rabies, or where rabies was unknown?</p> <p><b>If yes,</b><br/>         What kind of animal? _____<br/>         When? _____<br/>         Did you receive any medical treatment? _____<br/>         Was the animal suspected of having rabies? _____<br/>         Was the animal quarantined or tested? _____<br/>         If tested, what was the result? _____</p> | Y <input type="checkbox"/> | N <input type="checkbox"/> |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|

**Additional Information: Please provide additional information if you answered "yes" to questions 36I, 51C, 51D, or 51E in the questionnaire above.**

|           |    |                                                                                                                    |
|-----------|----|--------------------------------------------------------------------------------------------------------------------|
| <b>36</b> | I) | If you had an infection during your pregnancy please provide list of infections: _____                             |
| <b>51</b> | C  | If you ever lived or worked in a high congregate setting please list when: _____ and where: _____                  |
|           | D  | If you have traveled, lived, or was born in an area where TB is common please provide when: _____ and where: _____ |
|           | E  | If you have impaired immunity, please list what type: _____                                                        |

**INITIAL REVIEW**      *TO BE COMPLETED BY CFL AFFILIATE COLLECTION SPECIALIST, ONLY*

I have performed and reviewed the above responses and have determined this HQ initial status to be (☒ one):

☐ **Acceptable** –All CFL HQ requirements met.     
 ☐ **Follow Up** – Further follow up by CFL required for final status determination.

Reviewed By: \_\_\_\_\_

Date(s): \_\_\_\_\_

**CFL REVIEW**      *TO BE COMPLETED BY CORD FOR LIFE, INC (CFL) ONLY*

| CLIENT SERVICES REVIEW ( <input checked="" type="checkbox"/> one) <input type="checkbox"/> N/A |                  |                          |            | LABORATORY REVIEW ( <input checked="" type="checkbox"/> one) |                  |                          |            |
|------------------------------------------------------------------------------------------------|------------------|--------------------------|------------|--------------------------------------------------------------|------------------|--------------------------|------------|
| <input type="checkbox"/>                                                                       | HQ-OK            | <input type="checkbox"/> | Defer      | <input type="checkbox"/>                                     | HQ-OK            | <input type="checkbox"/> | Defer      |
| <input type="checkbox"/>                                                                       | Unusual Findings | <input type="checkbox"/> | Ineligible | <input type="checkbox"/>                                     | Unusual Findings | <input type="checkbox"/> | Ineligible |
| <input type="checkbox"/>                                                                       | Other: _____     |                          |            | <input type="checkbox"/>                                     | Other: _____     |                          |            |
| Reviewed By: _____                                                                             |                  |                          |            | Reviewed By: _____                                           |                  |                          |            |
| Date(s): _____                                                                                 |                  |                          |            | Date(s): _____                                               |                  |                          |            |



## DONATION INFORMED CONSENT AND RELEASE - HOSPITAL/BIRTHING CENTER

I, the undersigned, desire the collection of my unborn baby's cord blood for donation. I have elected to utilize the services of Cord For Life to achieve the desired donation. For the donation to occur it is necessary to collect and save the blood from the placenta and umbilical cord after the birth of my baby, rather than discard the blood as medical waste. The collected cord blood will be shipped to Cord For Life for processing and placement into storage.

My physician, physician's designee, midwife or a Cord For Life trained and collection specialist will perform the collection of the cord blood after the delivery of my baby, while the delivery of the placenta occurs. He/she will use methods provided by Cord For Life in their standard operational procedures. Medical conditions may arise which preclude the collection of the cord blood and will be decided at the sole discretion of the attending physician.

I understand that the donation of cord blood includes medical procedures and that there can be no guarantee or assurance of success of the results of the service. I further, on behalf of myself and my unborn baby, our respective heirs, successors and assigns, hereby release and forever hold harmless the Hospital / Birthing Center, and its affiliates, successors, assigns, officers, directors, employees and agents from any and all actions, causes of action, claims, debts, demands, liabilities, covenants, controversies, omissions and damages and any and all other claims of every kind, nature, and description whatsoever, both in law and equity, which may arise relating to the collection of the cord blood on behalf of me and my unborn baby. It is important that you inform Cord For Life if the baby develops a serious disease that may pose a risk to future recipients.

I approve the sharing of any/all testing results with other medical or research facilities that are in partnership with Cord For Life and whose standards and policies follow all confidentiality measures as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### PHYSICIAN - DONATED SAMPLE

My patient desires the collection of her unborn baby's cord blood for donation to Cord For Life. For the donation to occur, it is necessary to collect and save the blood from the placenta and umbilical cord after the birth of my patient's baby, rather than discard the blood as medical waste. The cord blood obtained will be shipped to Cord For Life for processing and placement into storage.

Myself or a Cord For Life trained and approved collection specialist will perform the collection of the cord blood after the birth of her baby, while the delivery of the placenta occurs. The collection will use the methods provided by Cord For Life in their standard operational procedures. The collection period will be brief and Cord For Life will provide the protocols and collection equipment in the kit. Every effort will be used to acquire as much cord blood as is feasible and will minimize the risk of fungal, bacterial or maternal blood contamination.

**The health and welfare of my patient and her baby are the primary concern and responsibility and accordingly I reserve the right to forgo the collection of the cord blood if my best medical judgment indicates this to be necessary.**

I understand that the donation of cord blood includes medical procedures and that there can be no guarantee or assurance of success of the results of the service. I, on behalf of myself, my heirs and successors and assigns hereby release and forever discharge Cord For Life and its affiliates, successors, assigns, officers, directors, employees and agents from any and all actions, causes of actions, demands, debts, claims liabilities, covenants and damages and any and all other claims of every kind, nature and description whatever, both in law and equity, which may arise relating to my performing the collection of the cord blood.

Cord For Life, on behalf of itself, its affiliates, assigns, officers, directors, employees and agents releases and forever discharges me and each of my heirs, successors and assigns from any and all actions, causes of actions, demands, debts, claims, liabilities, covenants and damages and any and all other claims of every kind, nature and description whatever, both in law and equity, which may arise relating to my performing the collection of the cord blood.

My patient, \_\_\_\_\_, releases me and each of my heirs, successors, and assigns from any and all actions, causes of action, claims, debts, demands, liabilities, covenants, controversies, omissions and damages and any and all other claims of every kind, nature and description whatsoever, both in law and equity, which may arise relating to my performing the collection of the cord blood.

In addition, I understand that the donation of cord blood is a voluntary program, and as such, I will **not** receive reimbursement from Cord For Life for my services in the collection of the cord blood unit. I hereby agree to perform the cord blood collection for my patient on behalf of Cord For Life as outlined herein.

\_\_\_\_\_  
Signature of Expectant Mother (Required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician/Midwife ((Required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name of Expectant Mother

\_\_\_\_\_  
Print Name (Physician/Midwife)

**IMPORTANT:** THIS PAGE IS **REQUIRED** TO BE SIGNED BY YOU AND YOUR PHYSICIAN/MIDWIFE IN ORDER TO RECEIVE A CORD FOR LIFE CORD BLOOD DONATION COLLECTION KIT. TO AVOID ANY DELAYS IN YOUR PAPERWORK REVIEW, PLEASE ENSURE THAT ALL REQUIRED SIGNATURES ARE PRESENT PRIOR TO SUBMITTING YOUR FORMS.



## INFORMED CONSENT FOR THE INFECTIOUS DISEASE TESTING

### HUMAN IMMUNODEFICIENCY VIRUS AND TRANSMISSION:

Human Immunodeficiency Virus (HIV) is a virus which can be transmitted from individuals through body fluids, primarily blood and semen. The spread is not through air or food or by casual social contact. It is passed on when the blood or body fluids of an infected person mix with your own. Sexual transmission is mainly the result of the transfer of and exposure to infected semen. Women as well as men can transmit the virus sexually. The HIV virus has also been detected in vaginal secretions, tears, and saliva, but exposure to saliva has not been proven to transmit the infection. Intravenous drug users and persons receiving blood transfusions can be exposed to the virus through infected blood or body products. A baby may become infected during pregnancy, delivery, or when breast feeding if its mother has the disease. A person may carry the virus for months before testing positive and may carry the virus for months or years before the symptoms appear. An HIV positive person can still spread the disease even though he or she may appear healthy.

When HIV enters the blood stream it invades and destroys cells in the body's infection and cancer fighting system and reduces the body's ability to fight infections. The HIV virus leads to the depletion of the immune system to a point that infections which one wouldn't normally get (opportunistic infections) start developing, at which point the patient has AIDS. The HIV virus is not what kills a person with AIDS, it is the opportunistic infections which cause death.

### BEHAVIORS THAT INCREASE YOUR RISK OF BEING EXPOSED TO HIV:

Recent blood, plasma, or blood product transfusion, intravenous drug use, especially with sharing of needles or syringes, or having sexual contact with someone who: has tested positive for HIV infection, is at risk of infection through sexual practices, IV drug use, or recent blood transfusion, uses illicit intravenous drugs, received blood transfusions, plasma, or clotting factor before 1985 or within the last twelve months, has more than one sexual partner, especially ones who could be at risk of HIV infection, or is a man who has had sexual relations with another man.

### THE HIV TEST AND VOLUNTARY TESTING

The HIV tests are blood tests for the presence of the HIV virus and antibodies to the HIV virus. A positive test result means that you have been exposed to the virus, and either have made antibodies or are infected. It may not mean that you have AIDS now or that you will become sick with AIDS in the future. A negative test means that you are probably not infected with the virus. It takes about 12 days to detect the virus from time of infection to time of detection.

Taking the HIV test is voluntary, and results are confidential by law. Results can only be given to people you allow, and a release form must be signed prior to releasing this information. The law requires Cord For Life to report any positive HIV test result to the County Health Department.

### CONSENT (REQUIRED)

I have read the above information and have had my questions about the HIV test answered. I agree to take the HIV test. I allow the test results to be made available to Cord For Life and to my private physician,

Dr. \_\_\_\_\_.

Printed Full Name of Expectant Mother's: \_\_\_\_\_ Date: \_\_\_\_\_

Expectant Mother's Signature (full name as printed above): \_\_\_\_\_

### PHYSICIAN'S ORDER FOR BLOOD TESTING (REQUIRED)

**Rx** Patient Name: \_\_\_\_\_

**➡** It is an FDA requirement that Cord For Life performs maternal blood testing. **Tubes will be included with the cord blood collection kit to be drawn at the hospital/birthing center during labor and delivery.**

#### **ORDER: Maternal Blood Draw for:**

HIV-1 and HIV-2 (antibody to the AIDS virus)  
HEPATITIS B (HBsAg & HBcAb)  
HTLV-I and HTLV-II  
CMV,  
WNV

HCV/HIV NAT (Hepatitis C and AIDS virus by Nucleic Acid Test)  
HEPATITIS C VIRUS (Anti-HCV)  
SYPHILIS,  
ABO Rh  
CHAGAS DISEASE

Printed Name of Physician or Midwife: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Physician or Midwife: \_\_\_\_\_

**IMPORTANT:** THIS PAGE IS **REQUIRED** TO BE SIGNED BY YOU AND YOUR PHYSICIAN/MIDWIFE IN ORDER TO RECEIVE A CORD FOR LIFE CORD BLOOD DONATION COLLECTION KIT. TO AVOID ANY DELAYS IN YOUR PAPERWORK REVIEW, PLEASE ENSURE THAT ALL REQUIRED SIGNATURES ARE PRESENT PRIOR TO SUBMITTING YOUR FORMS.



## PHYSICIAN/MIDWIFE CB COLLECTION TRAINING REQUEST

Dear Healthcare Professional,

As you now know, your patient desires to have her baby's umbilical cord blood collected for either private storage or public donation. Cord For Life is registered with the FDA, a member of the National Marrow Donor Program and is accredited by the AABB, and we must ensure in every way possible that the collection process is successful. A quality collection is the biggest predictor in converting a donated cord blood unit into a transplantable product.

To ensure a high quality, high volume sample, we would like to offer you, at no cost, self training for the collection procedure. You also have the ability to state that you are well aware of the collection procedure and do not desire any further information. A one-page collection instruction sheet is also included in the collection kit sent to the donor mother. The donor mother will bring this kit to the hospital/birthing center at the time of delivery/collection.

We appreciate your time and support of this potentially life-saving program. Without your efforts, we would not be able to meet the increasing demands for stem cell transplants around the world.

=====

**IMPORTANT: Response to the following options is mandatory for regulatory compliance. If not completed a collection kit cannot be forwarded:**

**Physician/Midwife Name:** \_\_\_\_\_

|                          |                 |                                                                                                                                                                                      |
|--------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <b>OPTION 1</b> | I have collected umbilical cord blood before, and I am comfortable with the procedure, I do not require additional training.                                                         |
| <input type="checkbox"/> | <b>OPTION 2</b> | I will review the electronic collection videos on the Cord For Life website <a href="http://www.cordforlife.com">www.cordforlife.com</a> ( <i>Healthcare Professional Section</i> ). |
| <input type="checkbox"/> | <b>OPTION 3</b> | Please contact me regarding alternate collection training options.<br>Phone: _____ E-mail: _____                                                                                     |

Comments / Recommendations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### For CORD FOR LIFE staff, only

- ☐ Physician / Midwife has stated they were previously trained for cord blood collection.
- ☐ I have verified the Physician/Midwife, named above, has reviewed the Cord For Life Training video.
- ☐ I have contacted the Physician/Midwife, named above, and provided the following
  
- ☐ I was unable to verify completion of training for the Physician/Midwife, named above. Collection instructions (Form C.1-2) have been forwarded to ensure adherence to the Cord For Life collection protocol.

Employee: \_\_\_\_\_

Date: \_\_\_\_\_



**Collection Partner of the Cord for Life Foundation**  
**Informed Consent for Cord Blood Medical Research**

**I. INVITATION AND PURPOSE**

You are invited to donate your baby's cord blood for medical research if it cannot be used as a transplant product. You are being invited because you have already agreed to donate your baby's cord blood to the **Cord for Life®** Program for patients in need of a transplant. There are many reasons that cord blood may not meet the requirements for transplant. Cord blood not meeting these requirements can be used for medical research.

**Cord for Life®** Program provides investigators cord blood units to use in medical research. Although the exact studies for which cord blood units may be used is not known at this time, the following are types of studies in which these units may be included: Disease Treatment or Regenerative Medicine under Clinical Trials and Investigational New Biological Drug development.

In addition, researchers will conduct research studies with cord blood units that have had all identifiers removed. In these studies, there will be no way for the unit to be linked to you. The **Cord for Life®** Program may allow researchers to use these anonymous cord blood units for many other kinds of studies. These studies are not limited to the types of studies listed above or related to transplantation in general.

It is important that you inform Cord For Life if the infant donor develops a serious disease. You may receive a follow-up letter requesting follow-up information on your baby's health

*"With this donation of your cord blood, you are agreeing that your donated cord blood may be used for stem cell transplantation (also known as bone marrow transplant), for research and development, or in commercial products that may be used to help people with their medical problems. This donation will not result in any financial payment to you. Once your cord blood is donated you will not have a say in how it will be used for transplant, research or commercial purposes and it cannot be returned once it is used."*

**II. PROCEDURES**

If you agree to donate your baby's cord blood unit for medical research, nothing additional is required from you. After the cord blood is collected it will be tested to see if it meets all the requirements for transplant. If, **and only if**, it does **not** meet the requirements for transplant, the cord blood may be used for medical research. All research studies using cord blood must first be approved by the **Cord for Life®** scientific board, and executive and quality management.

**III. POSSIBLE RISKS AND BENEFITS**

There are no physical risks to you or your baby by donating the cord blood to be used in medical research. The decision to use the cord blood for medical research is only made after the cord blood is collected and it does not meet the requirements for transplant.

There is a very small risk that an unauthorized person could find out which cord blood unit is your baby's. The **Cord for Life®** Program has several procedures in place to keep your data private. No identifiable information about you will be given to the researchers, nor will it be published or presented at scientific meetings.

You or your baby will not be helped by donating your baby's cord blood for medical research. However, this research may help future patients who need a transplant or other therapeutic medical treatment.

**IV. CONFIDENTIALITY**

The **Cord for Life®** Program follows all HIPAA regulations and will not knowingly disclose that you donated your baby's cord blood for medical research. The **Cord for Life®** Program will try hard to make sure no one outside the **Cord for Life®** Program will know which cord blood unit is yours.

**V. REIMBURSEMENT AND COSTS**

You will not be paid for donating your baby's cord blood for medical research. It will not cost you anything to donate your baby's cord blood for medical research.

**Cord for Life®**, Inc. (CFL)

270 Northlake Blvd., Suite 1012, Altamonte Springs, FL 32701  
(800) 869-8608 / (407) 834-8333





## Collection Partner of the Cord for Life Foundation

### VI. **VOLUNTARY PARTICIPATION IN AND WITHDRAWAL**

It is up to you if you want to donate your baby's cord blood for medical research. If you choose not to, your unit will be discarded as medical waste.

If you decide to donate your baby's cord blood for medical research, you may change your mind at any time in the future. If you decide you do not want your baby's cord blood used for medical research, your baby's cord blood will be destroyed if it has not already been used. This will not affect your relationship with **Cord for Life®**. To withdraw your unit, forward a notarized letter to the **Cord for Life®** Client Services Department.

### VII. **ALTERNATIVE TO PARTICIPATION**

You may choose not to donate your baby's cord blood for medical research. If you choose not to, your unit will be discarded as medical waste.

### VIII. **QUESTIONS OR CONCERNS**

If you have questions, concerns, or complaints about donating your baby's cord blood for medical research contact Donald Hudspeth (Director of Laboratory Operations) at [dhudspeth@cordforlife.com](mailto:dhudspeth@cordforlife.com) or Kathryn Dunbar (Director of Quality Assurance) at [kdunbar@cordforlife.com](mailto:kdunbar@cordforlife.com).

If you have questions or concerns about your rights as a research subject or about potential risks and injuries, please contact Donald Hudspeth (Director of Laboratory Operations) at [dhudspeth@cordforlife.com](mailto:dhudspeth@cordforlife.com).

### IX. **DONOR ADVOCACY**

If you have additional concerns and desire information from an impartial source, **Cord for Life®** suggests visiting the following websites:

NMDP-Be the Match® Program: <https://bethematch.org/Support-the-Cause/Donate-cord-blood/>

Parents' Guide to Cord Blood: <http://parentsguidecordblood.org/>

Save the Cord Foundation: <http://www.savethecordfoundation.org/>

### X. **SUBJECT'S STATEMENT OF CONSENT**

I have read both pages of this consent form and I have been given the opportunity to ask questions. I voluntarily agree to donate my baby's cord blood for medical research studies, if it cannot be used for transplantation, as defined in this consent form.

Donor Advocacy information was provided to me by **Cord for Life®**.

\_\_\_\_\_  
Mother's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother's Printed Name

## **FOR COMPLETION BY CORD FOR LIFE, INC. REPRESENTATIVE**

Certification of Counseling Healthcare Professional

I certify that the nature and purpose, the potential benefits, and possible risks associated with donating umbilical cord blood for research have been explained to the above individual and that any questions about this information have been answered.

\_\_\_\_\_  
Counseling Healthcare Professional

\_\_\_\_\_  
Date

**Use of an Interpreter:** Complete if the subject is not fluent in English and an interpreter was used to obtain consent.

Print name of interpreter: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of interpreter: \_\_\_\_\_ Date: \_\_\_\_\_

An oral translation of this document was administered to the subject in \_\_\_\_\_  
(state language) by an individual proficient in English and \_\_\_\_\_  
(state language). See the attached short form addendum for documentation.

**Cord for Life®**, Inc. (CFL)

270 Northlake Blvd., Suite 1012, Altamonte Springs, FL 32701  
(800) 869-8608 / (407) 834-8333