Cord For Life® Cord Blood Donation Information

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. 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 34th 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 your documentation, on receipt. You will be contacted, by phone, 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.** We will dispatch a courier to pick up the cord blood within the next business day.

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

DONOR INFORMATION AND HEALTH HISTORY

MOTHER'S LAST NAME	FIRST NAME	M.I.	LAST 4 SS# DIGITS

BEST CONTACT PHONE:	EMAIL	MOTHER'S DOB:

ADDRESS	CITY	STATE	ZIPCODE

FATHER'S LAST 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 ethic 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

	Alaska Native or Aleut (ALANAM)
	North American Indian (AMIND)
	American Indian South or Central American (AMIND)
	Caribbean Indian (AMIND)

Black or African American

	African (AFB)
	African American (AAFA)
	Black Caribbean (CARB)
	Black South or Central American (SCAMB)

Asian

	Chinese (NCHI)
	Filipino (Philipino) (FILI)
	Japanese (JAPI)
	Korean (KORI)
	South Asian (SCSEAI)
	Vietnamese (SCSEAI)
	Other Southeast Asian (SCSEAI)

Native Hawaiian or Other Pacific Islander

	Guamanian (OPI)
	Hawaiian (HAWI)
	Samoan (OPI)
	Other Pacific Islander (OPI)

White

	Eastern European (CAU)
	Mediterranean (CAU)
	Middle Eastern (MENAFC)
	North Coast of Africa (MENAFC)
	North American (CAU)

	Northern European (CAU)
	Western European (CAU)
	White Caribbean (CAU)
	White South or Central American (CAU)
	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 Cord For Life, Inc. (CFL): 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. Please refer to Cord For Life, Inc. (CFL) Notice of Privacy Practices included in this packet.

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 1-7 of Form, B.1-1 is true and accurate to the best of my knowledge.

EXPECTANT MOTHER SIGNATURE:_____ **DATE:**_____

HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: _____ **MOTHER'S DOB:** _____

CORD BLOOD MATERNAL QUESTIONS

Please *read carefully* and *answer each* of the following questions *individually* "Y" for "YES" or "N" for "NO". Please provide details including dates, where requested, for all "Y" responses (except for #38 and #73)

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 ☐	N ☐
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? ***If yes***, why?	Y ☐	N ☐
3	Have you taken any of the following medications (check all that apply): a. ☐ **Insulin from cows (bovine or beef insulin) since 1980?** b. ☐ **Growth hormone from human pituitary glands ever?** c. ☐ **Rabies vaccination in the past 12 months.**	Y ☐	N ☐
4	**In the past 8 weeks,** have you had any shots or vaccinations? ***If yes***, details:	Y ☐	N ☐
5	**In the past 12 weeks**, 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 ☐	N ☐
6	**In the past 4 months,** have you experienced **TWO (2)** or more of the following: a fever (>100.5ºF or 38.6ºC), headache, muscle weakness, skin rash on trunk of the body, swollen lymph glands? **If yes**, which symptoms and when? Details::	Y ☐	N ☐
7	Have you ever had any type of cancer, including leukemia? ***If yes,*** details::	Y ☐	N ☐
8	**In the past 5 years,** have you had a bleeding problem, such as hemophilia or other clotting factor deficiencies, and received human-derived clotting factor concentrates? ***If yes,*** details:	Y ☐	N ☐
9	During your pregnancy, have you been diagnosed with West Nile Virus or had a positive test for West Nile Virus?	Y ☐	N ☐
10	Have you ever had a past diagnosis of clinical, symptomatic viral hepatitis after age 11? ***If yes,*** details, with dates:	Y ☐	N ☐
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 ☐	N ☐
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 ☐	N ☐
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 ☐	N ☐
14	Have you received a dura mater (brain covering) graft?	Y ☐	N ☐
15	Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an **animal**? Details:	Y ☐	N ☐
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 **animal**? ***If yes,*** details:	Y ☐	N ☐
17	**In the past 3 years**, have you had malaria? ***If yes,*** details:	Y ☐	N ☐
18	**In the past 3 years**, have you been outside the United States or Canada? Where: When: How Long:	Y ☐	N ☐
19	**In the past 12 months**, have you had a blood transfusion? Details:	Y ☐	N ☐
20	**In the past 12 months**, 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 ☐	N ☐
21	**In the past 12 months**, have you had a tattoo or piercing (ear, skin or body)? *If yes*, please indicate type and answer question **22.** ***If no,*** skip to question **23** **Type:** ☐ **Tattoo** ☐ **Piercing,** details:	Y ☐	N ☐
	22. ***If yes,*** were shared or non-sterile instruments, needles, or inks used for the tattoo or piercing?	Y ☐	N ☐

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 ☐	N ☐
24	**In the past 12 months**, have you had or been treated for a sexually transmitted disease, including syphilis? ***If yes,*** details with dates:	Y ☐	N ☐
25	**In the past 12 months** have you given money, drugs, or other payment to anyone to have sex with you?	Y ☐	N ☐
26	**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 **past 5 years**?	Y ☐	N ☐
27	**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 ☐	N ☐
28	**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 **past 5 years**?	Y ☐	N ☐
29	**In the past 12 months,** have you had sex with a male who has had sex with another male, even once, in the **past 5 years**?	Y ☐	N ☐
30	**In the past 12 months**, have you had sex, even once, with anyone who has taken human-derived clotting factors for a bleeding problem in the **past 5 years**?	Y ☐	N ☐
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 ☐	N ☐
32	**In the past 12 months,** have you been in juvenile detention, lockup, jail or prison for more than 72 ***continuous*** hours?	Y ☐	N ☐
33	**In the past 5 years** have you received money, drugs, or other payment for sex?	Y ☐	N ☐
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 ☐	N ☐
35	Do you have AIDS or have you ever tested positive for HIV (including screening tests)?	Y ☐	N ☐
36	**Do you have any of the following:**		
	A) Unexplained night sweats?	Y ☐	N ☐
	B) Unexplained blue or purple spots on or under the skin or mucous membranes?	Y ☐	N ☐
	C) Unexplained weight loss?	Y ☐	N ☐
	D) Unexplained persistent diarrhea?	Y ☐	N ☐
	E) Unexplained cough or shortness of breath?	Y ☐	N ☐
	F) Unexplained temperature higher than 100.5°F (38.6°C) for more than 10 days?	Y ☐	N ☐
	G) Unexplained persistent white spots or sores in the mouth?	Y ☐	N ☐
	H) Lumps in your neck, armpits, or groin lasting longer than one month?	Y ☐	N ☐
	I) Any infection during your pregnancy?	Y ☐	N ☐
37	Have you ever tested positive for HTLV-Human T-cell Lymphotrophic Virus (including screening tests) or had unexplained paraparesis (partial paralysis affecting the lower limbs)?	Y ☐	N ☐

38	***Do you understand*** that if you have the AIDS virus, ***you can give it to someone else*** even though you may feel well and have a negative AIDS test?	Y ☐	N ☐

HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: _____ **MOTHER'S DOB:** _____

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

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

39	**Since 1980**, have you ever lived in or traveled to Europe? (*refer to chart above*) ***If no***, skip to question **43.** 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. b) Answer questions **40** through **42**.	Y ☐	N ☐
	40. From 1980 through 1996, did you spend time that adds up to 3 months or more in the United Kingdom (*refer to chart above*)?	Y ☐	N ☐
	41. Since 1980, have you received a transfusion of blood or blood components while in the UK or France?	Y ☐	N ☐
	42. Since 1980, have you spent time that **adds up to 5 years or more** in Europe (*refer to chart above*), including time spent in the UK between 1980 and 1996?	Y ☐	N ☐
43	**From 1980 through 1996**, 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 ☐	N ☐
44	**From 1980 through 1990,** did you spend a **total of 6 months or more** associated with a military base in any of the following countries: United Kingdom, Belgium, Netherlands or Germany?	Y ☐	N ☐
45	**From 1980 through 1996,** did you spend a **total of 6 months or more** associated with a military base in any of the following countries: Spain, Portugal, Turkey, Italy or Greece?	Y ☐	N ☐

HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: _____ **MOTHER'S DOB:** _____

FOR USE WITH QUESTIONS 46-48: AFRICAN COUNTRIES

BENIN ____Travel ____Resident Date(s): Total Time:	**EQUATORIAL GUINEA** ____Travel ____Resident Date(s): Total Time:	**SENEGAL** ____Travel ____Resident Date(s): Total Time:
CAMEROON ____Travel ____Resident Date(s): Total Time:	**GABON** ____Travel ____Resident Date(s): Total Time:	**TOGO** ____Travel ____Resident Date(s): Total Time:
CENTRAL AFRICAN REPUBLIC ____Travel ____Resident Date(s): Total Time:	**KENYA** ____Travel ____Resident Date(s): Total Time:	**ZAMBIA** ____Travel ____Resident Date(s): Total Time:
CHAD ____Travel ____Resident Date(s): Total Time:	**NIGER** ____Travel ____Resident Date(s): Total Time:	
CONGO ____Travel ____Resident Date(s): Total Time:	**NIGERIA** ____Travel ____Resident Date(s): Total Time:	

46	**Since 1977**, were you born in, have you lived in, or have you traveled to any African country listed above? ***If yes***, answer question **47.** ***If no***, skip to question **48.** 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 ☐	N ☐
	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 ☐	N ☐
48	Have you had sexual contact with anyone who was born in or lived in any African country listed above **since 1977**?	Y ☐	N ☐
49	Were you and/or the baby's father adopted at early childhood?	Y ☐	N ☐
	If yes, is a family medical history available for you and/or the baby's father?	Y ☐	N ☐
50	Are you and the baby's father related, except by marriage? (e.g. first cousins)	Y ☐	N ☐
51	Did this pregnancy use either a donor egg or donor sperm?	Y ☐	N ☐
	If yes, is a family medical history questionnaire available for the egg or sperm donor? (please attach copy) Name of the Clinic: _____	Y ☐	N ☐
52	Have you ever had an abnormal result from a prenatal test (e.g. amniocentesis, blood test, and ultrasound)? If yes, answer the following questions. If no, skip to question 53.	Y ☐	N ☐
	A) Which test was abnormal? _____		
	B) What was the abnormal test result? _____		
	C) Was a diagnosis made? Specify diagnosis: _____		
53	Have you had any children who died within the first 10 years of life?	Y ☐	N ☐
	If yes, what was the cause? _____		
54	Have you ever had a stillborn child?	Y ☐	N ☐
	If yes, what was the cause? _____		
55	Have you had a medical diagnosis of ZIKV (Zika) infection at any point during your pregnancy?	Y ☐	N ☐
56	Have you resided in, or travel to, an area with active ZIKV (Zika) transmission at any point during your pregnancy?	Y ☐	N ☐
57	Have you had sex during your pregnancy with a male who is known to have: 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.	Y ☐	N ☐

HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: _____ **MOTHER'S DOB:** _____

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.)

58 Cancer or Leukemia? Y ☐ N ☐

If yes, please specify all that apply. *If no*, proceed to next question.

	BM	BF	BS
A) Brain or other nervous system cancer	☐	☐	☐
B) Bone or joint cancer	☐	☐	☐
C) Kidney (Including renal pelvic) cancer	☐	☐	☐
D) Thyroid Cancer	☐	☐	☐
E) Hodgkin's Lymphoma	☐	☐	☐
F) Non-Hodgkin's Lymphoma	☐	☐	☐
G) Acute or chronic myelogenous/myeloid leukemia	☐	☐	☐
H) Acute or chronic lymphocytic/lymphoblastic leukemia	☐	☐	☐
I) Skin Cancer	☐	☐	☐
J) Other cancer/leukemia Specify Type:_____ Specify Type:_____	☐	☐	☐

IMMEDIATE FAMILY ONLY

59 Red Blood Cell Y ☐ N ☐

If yes, please specify all that apply. *If no*, proceed to next question.

	BM	BF	BS	BGP	BMS	BFS
A) Diamond-Blackfan Syndrome	☐	☐	☐	☐	☐	☐
B) Elliptocytosis	☐	☐	☐	☐	☐	☐
C) G6PD or other red cell enzyme deficiency	☐	☐	☐	☐	☐	☐
D) Spherocytosis	☐	☐	☐	☐	☐	☐

60 White Blood Cell Disease? Y ☐ N ☐

If yes, please specify all that apply. *If no*, proceed to next question.

	BM	BF	BS	BGP	BMS	BFS
A) Chronic Granulomatous Disease	☐	☐	☐	☐	☐	☐
B). Kostmann Syndrome.	☐	☐	☐	☐	☐	☐
C) Schwachman-Diamond Syndrome	☐	☐	☐	☐	☐	☐
D) Leukocyte Adhesion Deficiency (LAD)	☐	☐	☐	☐	☐	☐

61 Immune Deficiencies? Y ☐ N ☐

If yes, please specify all that apply. *If no*, proceed to next question.

	BM	BF	BS	BGP	BMS	BFS
A) ADA or PNP Deficiency	☐	☐	☐	☐	☐	☐
B) Combined Immunodeficiency Syndrome (CID), Common Variable Immunodeficiency Disease (CVID)	☐	☐	☐	☐	☐	☐
C) DiGeorge Syndrome	☐	☐	☐	☐	☐	☐
D) Hereditary Hemophagocytic Lymphohistiocytosis (HLH) including FEL	☐	☐	☐	☐	☐	☐
E) Hypoglobulinemia	☐	☐	☐	☐	☐	☐
F) Nezeloff Syndrome	☐	☐	☐	☐	☐	☐
G) Severe Combined Immunodeficiency	☐	☐	☐	☐	☐	☐
H) Wiskott-Aldrich Syndrome	☐	☐	☐	☐	☐	☐

HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: _____ **MOTHER'S DOB:** _____

	Platelet Disease?	Y ☐	N ☐							
	***If yes**, please specify all that apply. **If no**, proceed to next question*			BM	BF	BS	BGP	BMS	BFS
62	A) Amegakaryocytic Thrombocytopenia			☐	☐	☐	☐	☐	☐
	B) Glanzmann Thrombasthenia			☐	☐	☐	☐	☐	☐
	C) Hereditary Thrombocytopenia			☐	☐	☐	☐	☐	☐
	D) Platelet Storage Pool Disease			☐	☐	☐	☐	☐	☐
	E) Thrombocytopenia with absent radii (TAR)			☐	☐	☐	☐	☐	☐
	F) Ataxia-Telangiectasia			☐	☐	☐	☐	☐	☐
	G) Fanconi Anemia			☐	☐	☐	☐	☐	☐
63	**Any diagnosis of other platelet disease or disorder?** Specific Type: _____	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
	Hemoglobin Problems			BM	BF	BS	BGP	BMS	BFS
64	Sickle cell disease, such as sickle-cell anemia or sickle thalassemia? Specify disease: _____	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
65	Thalassemia, such as alpha thalassemia or beta-thalassemia?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
	Metabolic/Storage Disease?	Y ☐	N ☐						
	***If yes**, please specify all that apply. **If no**, proceed to next question.*			BM	BF	BS	BGP	BMS	BFS
66	A) Hurler Syndrome (MPS I)			☐	☐	☐	☐	☐	☐
	B) Hurler-Scheie Syndrome (MPS I H-S)			☐	☐	☐	☐	☐	☐
	C) Hunter Syndrome (MPS II)			☐	☐	☐	☐	☐	☐
	D) Sanfilippo Syndrome (MPS III)			☐	☐	☐	☐	☐	☐
	E) Morquio Syndrome (MPS IV)			☐	☐	☐	☐	☐	☐
	F) Maroteaux-Lamy Syndrome (MPS VI)			☐	☐	☐	☐	☐	☐
	G) Sly Syndrome (MPS VII)			☐	☐	☐	☐	☐	☐
	H) I-cell disease			☐	☐	☐	☐	☐	☐
	I) Globoid Leukodystrophy (Krabbe Disease)			☐	☐	☐	☐	☐	☐
	J) Metachromatic Leukodystrophy (MLD)			☐	☐	☐	☐	☐	☐
	K) Adrenoleukodystrophy (ALD)			☐	☐	☐	☐	☐	☐
	L) Sandhoff Disease			☐	☐	☐	☐	☐	☐
	M) Tay-Sachs Disease			☐	☐	☐	☐	☐	☐
	N) Gaucher Disease			☐	☐	☐	☐	☐	☐
	0) Niemann Pick-Disease			☐	☐	☐	☐	☐	☐
	P) Porphyria			☐	☐	☐	☐	☐	☐
	Q) Other or unknown metabolic/storage disease, Details:			☐	☐	☐	☐	☐	☐
	Acquired Immune System Disorders			BM	BF	BS			
67	**HIV/AIDS?**	Y ☐	N ☐	☐	☐	☐			
	Severe autoimmune disorder?	Y ☐	N ☐	☐	☐	☐			
	If yes**, please specify all that apply including providing the other requested information. **If no, proceed to next question.			BM	BF	BS			
68	A) Crohn's Disease or Ulcerative Colitis			☐	☐	☐			
	B) Lupus			☐	☐	☐			
	C) Multiple Sclerosis (MS)			☐	☐	☐			
	D) Rheumatoid Arthritis			☐	☐	☐			
	Diagnosis Date: _____ Currently under MD care? Describe: _____ Currently taking any medication? Name: _____								

IMMEDIATE FAMILY ONLY

HEALTH QUESTIONNAIRE

MOTHER'S LAST 4 SS# DIGITS: _____ **MOTHER'S DOB:** _____

				BM	BF	BS	IMMEDIATE FAMILY ONLY		
69	Any diagnosis of other or unknown immune system disorder? Specify Disorder: _____	Y ☐	N ☐	☐	☐	☐			
				BM	BF	BS	BGP	BMS	BFS
70	Required Chronic Blood Transfusions?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
71	Been told you or your family member(s) have hemolytic anemia?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
72	Had spleen removed to treat a blood disorder?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
73	Had gallbladder removed before the age of 30?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
74	Had Creutzfeldt-Jakob disease (CJD)?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
75	Other serious or life-threatening diseases affecting the family?	Y ☐	N ☐	BM	BF	BS	BGP	BMS	BFS
	If yes, list affected family member(s) and type of disease								
	Specify Type: _____			☐	☐	☐	☐	☐	☐
	Specify Type: _____			☐	☐	☐	☐	☐	☐
	Specify Type: _____			☐	☐	☐	☐	☐	☐

76	In answering these questions, have you answered for both your family and the baby's father's family?	Y ☐	N ☐

Addendum A: STATE OF NEW YORK-ONLY For collections within the State of NY, the following questions must be answered.

1.	Any history of acute respiratory disease? ***If Yes***, please describe _____	Y ☐	N ☐
2.	Any active tuberculosis disease or history of tuberculosis therapy? ***If Yes***, please describe	Y ☐	N ☐
3.	Any history of drug or alcohol abuse? ***If Yes***, please describe _____	Y ☐	N ☐

Addendum B: Severe Acute Respiratory Syndrome (SARS)

Only during time of person-to-person transmission of SARS, the following questions must be answered:

1.	**In the past 28 days**, have you been ill with SARS or suspected SARS?	Y ☐	N ☐
2.	**In the past 14 days**, have you cared for, lived with, or had direct contact with body fluids of a person with SARS or suspected SARS?	Y ☐	N ☐
3.	**In the past 14 days,** have you traveled outside of the United States?	Y ☐	N ☐
4.	**In the past 14 days,** has someone you live with traveled to, traveled through, or resided in areas affected by SARS?	Y ☐	N ☐
5.	**In the past 14 days,** do you believe you have been exposed to SARS or to someone who has traveled to, traveled through, or resided in areas affected by SARS?	Y ☐	N ☐

TO BE COMPLETED BY CORD FOR LIFE, INC (CFL): ☐ **N/A** Person-to-person transmission of SARS not occurring.
LC Employee Initials/Date(s): _____

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

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

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

Reviewed By: **Date(s):**

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

CLIENT SERVICES REVIEW (☑ *one*) ☐ N/A				LABORATORY REVIEW (☑ *one*)			
☐	**HQ-OK**	☐	**Defer**	☐	**HQ-OK**	☐	**Defer**
☐	**Unusual Findings**	☐	**Ineligible**	☐	**Unusual Findings**	☐	**Ineligible**
☐	**Other:**			☐	**Other:**		
Reviewed By:		**Date(s):**		**Reviewed By:**		**Date(s):**	

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.

Studies to:

- Disease Treatment
- Regenerative Medicine

In addition, researchers may 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.

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, executive and quality management.

III. *POSSIBLE RISKS AND BENEFITS*

There are no physical risks to your or 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 HIPPA regulations and will not intentionally tell anyone 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 – 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.

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.

Collection Partner of the Cord For Life® Foundation

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 don't 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 – Cord for Life Program. To withdraw your unit forward a notarized letter to 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@cordforlifecom or Denise Clifton *(Director of Quality Assurance)* at dsardone@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.

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: _____

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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
www.cordforlife.com

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.

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

Physician/Midwife Name: _____

☐	**OPTION 1**	I have collected umbilical cord blood before, and I am comfortable with the procedure, I do not require additional training.
☐	**OPTION 2**	I will review the electronic collection videos on the Cord For Life website www.cordforlife.com (*Healthcare Professional Section*).
☐	**OPTION 3**	Please contact me regarding alternate collection training options. 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: _____

Cord For Life, Inc. (CFL)
270 Northlake Blvd., Suite 1012
Altamonte Springs, FL 32701