Collection Partner of the Cord for Life Foundation

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 Lifeforce Cryobanks, if you need help understanding any of the questions, please call Lifeforce Cryobanks: 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 Lifeforce Cryobanks 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 Lifeforce Cryobanks. 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 or Lifeforce Cryobanks? 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), dementia, and 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 100.5ºF (38.6ºC) 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 ☐**

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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**
DEMARK _____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, 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? _____		

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.)

55 Cancer or Leukemia? Y ☐ N ☐

If yes, please specify all that apply in **59A-J**. *If no*, skip to question **56.**	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

Answer Questions **56-60** for any Blood Disorders or Diseases. ***If yes*,** please specify as applicable.

56 Red Blood Cell Y ☐ N ☐

If yes, please specify all that apply in **56A-D**. *If no*, skip to question **57.**	BM	BF	BS	BGP	BMS	BFS
A) Diamond-Blackfan Syndrome	☐	☐	☐	☐	☐	☐
B) Elliptocytosis	☐	☐	☐	☐	☐	☐
C) G6PD or other red cell enzyme deficiency	☐	☐	☐	☐	☐	☐
D) Spherocytosis	☐	☐	☐	☐	☐	☐

57 White Blood Cell Disease? Y ☐ N ☐

If yes, please specify all that apply in **57A-D**. *If no,* skip to question **58.**	BM	BF	BS	BGP	BMS	BFS
A) Chronic Granulomatous Disease	☐	☐	☐	☐	☐	☐
B). Kostmann Syndrome.	☐	☐	☐	☐	☐	☐
C) Schwachman-Diamond Syndrome	☐	☐	☐	☐	☐	☐
D) Leukocyte Adhesion Deficiency (LAD)	☐	☐	☐	☐	☐	☐

58 Immune Deficiencies? Y ☐ N ☐

If yes, please specify all that apply in **58A-H**. *If no*, skip to question **59.**	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: _____**

59	**Platelet Disease?**	**Y** ☐	**N** ☐					
	If yes, *please specify all that apply in 59A-G. If no, skip to question 60.*			**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**
	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			☐	☐	☐	☐	☐	☐
60	**Any diagnosis of other platelet disease or disorder?** Specific Type**:** _____	**Y** ☐	**N** ☐	☐	☐	☐	☐	☐	☐
	Hemoglobin Problems			**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**
61	Sickle cell disease, such as sickle-cell anemia or sickle thalassemia? Specify disease:_____	**Y** ☐	**N** ☐	☐	☐	☐	☐	☐	☐
62	Thalassemia, such as alpha thalassemia or beta-thalassemia?	**Y** ☐	**N** ☐	☐	☐	☐	☐	☐	☐
63	**Metabolic/Storage Disease?**	**Y** ☐	**N** ☐					
	If yes**,** please specify all that apply in **63A-Q**. ***If no*****,** skip to question **64.**			**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**
	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**	**IMMEDIATE FAMILY ONLY**		
64	**HIV/AIDS?**	**Y** ☐	**N** ☐	☐	☐	☐			
65	**Severe autoimmune disorder?**	**Y** ☐	**N** ☐	☐	☐	☐			
	If yes**,** please specify all that apply in questions **65A-D**. ***If no*****,** skip to question **66.**			**BM**	**BF**	**BS**			
	A) Crohn's Disease or Ulcerative Colitis			☐	☐	☐			
	B) Lupus			☐	☐	☐			
	C) Multiple Sclerosis (MS)			☐	☐	☐			

	D) Rheumatoid Arthritis			☐	☐	☐
66	Any diagnosis of other or unknown immune system disorder?	**Y** ☐	**N** ☐	**BM**	**BF**	**BS**
	Specify Disorder:_____			☐	☐	☐

Content Owner : Mary Herlihy, MD
Date last reviewed : 02/05/2016

Collection Partner of the Cord for Life Foundation

HEALTH QUESTIONNAIRE

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

				BM	BF	BS	BGP	BMS	BFS
67	Required Chronic Blood Transfusions?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
68	Been told you or your family member(s) have hemolytic anemia?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
69	Had spleen removed to treat a blood disorder?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
70	Had gallbladder removed before the age of 30?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
71	Had Creutzfeldt-Jakob disease (CJD)?	Y ☐	N ☐	☐	☐	☐	☐	☐	☐
72	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:_____			☐	☐	☐	☐	☐	☐

73	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 LIFEFORCE CRYOBANKS: ☐ **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*** **LIFEFORCE CRYOBANKS** ***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):**	

Content Owner : Mary Herlihy, MD
Date last reviewed : 02/05/2016