



Public Cord Blood Donation Program Information

Please take a few minutes to read about the program. Complete the attached forms if you decide you want to donate your baby's cord blood. **You must be 18 years of age or older in order to donate your baby's cord blood.**

How the Donation Program Works:

1. Included in this packet is some basic information about cord blood donation, an informed consent form, a health questionnaire, and a doctor's order for the testing of your blood, and a physician/midwife cord blood collection inquiry form. Please read these materials carefully. There are some reasons that may exclude you from being able to donate your cord blood. If you consider yourself to be at risk as described in the donation information, please do not donate. The standards set forth for all blood banks prevent us from accepting or using any cord blood from an at risk donor.
2. If you do not have any risk factors described in the provided information, and you decide you want to participate in the donation program, **FILL OUT, SIGN AND RETURN the FOLLOWING FORMS:**

- Donor Information and Health questionnaire** (9 page form) – YOUR (Donor) signature is required on pages 7, 8 and 9 and PHYSICIAN signature is required on pages 8 and 9.
- Informed Consent for Donation of Cord Blood** (3 page form) – YOUR (Donor) signature is REQUIRED on page 3.
- Physician/Midwife CB Collection Inquiry Form** (1 page form) – To be completed by your PHYSICIAN/MIDWIFE and returned to Cryobanks International with all completed forms.

3. Talk to 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. Cryobanks 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 for doing so. Cryobanks cannot reimburse you or your doctor/midwife for cord blood collection fees.
4. Have your doctor or midwife complete the collection inquiry form, sign where indicated on the forms and sign on the order for your blood testing. We are required to test your blood for infectious diseases from a sample collected within 48 hours of your baby's birth, even if you have had previous prenatal testing done. 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.
Note: The results of your blood tests are confidential. You and your physician or nurse/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.
5. Please return all required forms with original signatures (by the end of your 35th week of pregnancy). Mail completed forms to:
Cryobanks International, Inc.
270 Northlake Blvd., Suite 1000
Altamonte Springs, FL 32701
6. Upon receipt of completed forms, we review your forms and health questionnaire. We will contact you 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).
7. When we ship your kit, you will also receive a copy of your health questionnaire and a verification card. The purpose of this card is to update any changes to your health status between the time you filled out your 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. We are required to have your documented health status within 48 hours of delivery.
8. 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.
9. Notify Cryobanks International upon the labor and delivery of your baby, day or night at (407) 834-8333 or 1-800-869-8608. **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.
10. Please inform Cryobanks International if there are any changes in your address, phone number or delivery due date. Contact us at any time for more information or questions regarding the public cord blood donation program.

**CRYOBANKS INTERNATIONAL
INFORMED CONSENT FOR DONATION OF CORD BLOOD
FOR CORD BLOOD BANKING AND TRANSPLANTATION RESEARCH**

I. BACKGROUND

Umbilical cord blood transplantation is a recent advancement in medical research. The first cord blood transplant took place in 1986. Initially, all cord blood transplants were from sibling donors. In the mid 1990's, researchers learned that cord blood from unrelated donors could also work to treat recipients with leukemia and other blood diseases. Most transplants have been done in children, and research is underway to study the use of unrelated cord blood transplantation in adults.

Before birth, a baby's blood cells move through his/her body, umbilical cord, and placenta. These blood cells carry oxygen and nutrition from the mother's blood to the baby. After the birth of a baby, the umbilical cord is clamped and cut, separating the baby from the placenta, which is delivered several minutes later and is usually discarded. The placenta contains one-third (1/3) to one-half (1/2) of a cup of blood. This blood is called umbilical cord blood. Cord blood is rich in blood stem cells, which is being studied for its usefulness in replacing the blood-forming cells in persons with certain diseases. These transplants are called either cord blood transplants or blood stem cell transplants.

Before you decide whether you want to be part of this study, you need to understand the purpose of the study and what you are being asked to do.

II. INVITATION AND PURPOSE

You are invited to donate your baby's cord blood to be listed on one or more International Registries to be made available for anyone in need of a stem cell transplant. The donation may also potentially be used in other types of research activities, including some that may involve humans. Any studies performed that involve humans will be properly approved by a certified Institutional Review Board (IRB). You are being asked because you are pregnant with a single, healthy baby or just delivered a healthy baby. One of the International Registries is the National Marrow Donor Program[®] (NMDP), who is coordinating a study of umbilical cord blood banking and transplantation. The purposes of this research study are:

- to examine the safety and efficacy of unrelated donor cord blood transplants,
- to evaluate the closeness in tissue type matching between the cord blood unit and recipient,
- to study other factors that contribute to transplant recipient survival such as how well the cord blood engrafts (grows in the body of the recipient),
- and to examine whether the way the cord blood is collected, processed and stored has any effects on survival and complications in transplant recipients.

III. YOUR INVOLVEMENT IN THE NMDP STUDY

You are being asked to consent to the collection, processing, testing, screening, storage, and registry listing of your baby's cord blood unit. If you decide to participate, your baby's cord blood unit may be listed with the NMDP registry for the purpose of transplantation. The NMDP registry is a national database where persons who need a transplant are matched against a list of donated cord blood units. The listing of a cord blood unit with the NMDP registry does not guarantee that the cord blood unit will ever be selected for transplantation.

Approximately 50% of cord blood units collected will not be stored for transplantation and therefore will not be listed with the NMDP registry. The most common reasons a cord blood unit is not eligible for being listed with the NMDP registry or being used for transplantation research is because the amount of blood collected is too small or it contains too few cells. If this is the case, the cord blood will be properly discarded, used in one of the other registries or saved for approved research in the future by a researcher who is investigating the various possible uses of umbilical cord blood. If your baby's cord blood unit meets the minimum requirements, it may be listed on the NMDP registry.

A variety of screenings and tests must be performed to determine that your baby's cord blood is suitable for transplantation. You will be asked questions related to your medical history, genetic history, sexual and social history. These questions are similar to the questions asked of volunteer blood donors and you may find some of these questions to be very personal. You will also be asked to provide health history information about the biological father and his family. The identity of the biological father and other family members are not recorded on any of the study forms. If you agree to participate, it is important that you are willing to answer these questions truthfully. You are free to refuse to answer any question. However, incomplete answers may disqualify the donated cord blood from being included in this study. It will take approximately 15-30 minutes for you to provide this information.

Within 48 hours of the birth of your baby, about 20 ml of blood will be drawn from you. Your blood will be tested for certain infectious diseases including HIV and hepatitis. This is done to reduce the chances of passing on an infectious disease through the transplantation of the cord blood unit. A sample of your baby's cord blood will be tested for red blood cell type (ABO, Rh) and tissue type. This allows for the cord blood unit to be matched to a potential recipient. A small sample of the cord blood will be frozen and stored and may be tested again for tissue type and ABO Rh.

The cord blood bank will test the cord blood for abnormal hemoglobin, such as sickle cell disease and thalassemia. The cord blood cannot be used for transplantation if your baby has sickle cell disease and/or thalassemia.

Form Number B.1-7 Rev. B	Page 1 of 3
Issue Date: 09JUL2007	NMDP IRB Approved 07/01/2007 through 06/30/2008 IRB-2002-0059; v4.1

The cord blood bank may review your baby's hospital records or may contact you directly for information regarding infections and congenital anomalies. This may be done either before you and your baby leave the hospital or after your baby's first post-delivery check-up.

Information about the umbilical cord blood unit, including the information regarding its tissue type, will be entered in the NMDP registry. Information from your medical history, genetic history, sexual and social history will also be entered in the NMDP registry. There will be no information in the registry that could be used to identify you or your baby. The cord blood unit is only listed by an identification number that provides a link to your records that are generated and kept by the cord blood bank. Only authorized staff members at the cord blood bank have access to your medical history, genetic history, sexual and social history (confidential information).

IV. POSSIBLE RISKS AND BENEFITS TO BEING IN THE STUDY

There will be no direct benefit to you or your baby if you take part in this study. Some study participants feel satisfied knowing that they and their baby may be able to help others by donating cord blood for cord blood banking and transplantation research, and/ or other types of research, including laboratory research.

The cord blood is collected after delivery of your baby either while the placenta is still in your body or after it has been delivered. The doctors and nurses have been instructed to never collect the cord blood if the process of collection would expose either you or your baby to any added health risk. There is no change in the actual delivery process. Furthermore, your doctor can cancel the cord blood collection at any time if he/she thinks it might pose a potential harm to you or your baby.

Blood (about 20 ml) will be taken from your arm for infectious disease marker tests. This may cause pain, bruising, infection or fainting.

The cord blood bank staff may review the hospital medical charts of you and your baby. They will look for prenatal test results including HIV (the virus that causes AIDS), syphilis, and hepatitis tests and other medical information that may be important for determining if your baby's cord blood unit should be listed on the registry.

It is possible that certain medical conditions, which were not apparent at the birth of your baby, may become known to the cord blood bank staff after testing of the cord blood. If they learn about these conditions in the future, they may contact you or your primary physician who may then inform you of the test results. If the infectious disease testing performed on your blood shows that you may have HIV (the virus that causes AIDS) or hepatitis, you will be informed by your physician or the cord blood bank personnel of these test results. This may cause you to have to deal with health concerns that may or may not happen in the future. In addition, if required by federal, state or local law, some positive results will be reported directly to your state health department.

The medical, genetic, sexual and social history questions that are asked are of a sensitive nature. Answering the questions may cause you to feel uncomfortable.

V. CONFIDENTIALITY

The records from this study maintained at the cord blood bank are kept private and confidential. The security of your and your baby's identifying information at the cord blood bank is verified by the NMDP during periodic inspections. The NMDP has received a security certification from the United States Health Resources and Services Administration (HRSA). Your name or your baby's name or other identifying information will not appear on the cord blood unit or on any study records maintained outside the cord blood bank. Authorized staff from the cord blood bank will have access to your or your baby's personal information. Your cord blood bank and the NMDP will not disclose your or your baby's participation by any means of communication to any person or organization, except by your written request or permission, or unless required by federal, state or local laws, or regulatory agencies. You will not know who receives the cord blood. The recipient of the cord blood will not be given the identity of you or your baby.

Required Audits and Inspections

Individuals authorized by the cord blood bank, the NMDP and the Food and Drug Administration (FDA) will have access to your or your baby's donor medical charts (i.e., the donor and medical charts maintained on you and your baby as a donor) for inspections or audits. In agreeing to participate, you consent to such inspections and to the copying of excerpts from these records, if required to meet regulatory requirements.

Research Presentations

Scientific and medical findings resulting from the study may be presented at meetings or published so that the information can be useful to others. Nothing in such presentations or publications would reveal your or your baby's identity or participation in this study.

VI. VOLUNTARY PARTICIPATION IN AND WITHDRAWING FROM THE STUDY

Your consent for the collection and storage of your baby's cord blood is your choice. It is entirely voluntary. If you choose not to take part in the study, neither your care nor your baby's care will be negatively affected.

If you agree to continue in this study, you can change your mind. You can stop participating in the study any time before the shipment of your baby's cord blood unit for transplantation. However, your baby's cord blood cannot be withdrawn from the study after it has been transplanted or used in other types of research. If you withdraw from the study and your baby's cord blood is still in frozen storage at the cord blood bank, the cord blood bank may destroy the cord blood according to their procedures. A written notarized letter from the donor must be sent to the cord blood bank where

Form Number B.1-7 Rev. B	Page 2 of 3
Issue Date: 09JUL2007	NMDP IRB Approved 07/01/2007 through 06/30/2008 IRB-2002-0059; v4.1

the cord blood is stored, in order for the cord blood to be removed from the study.

VII. ALTERNATIVE TO PARTICIPATION

You can choose not to donate the cord blood. If you do not donate the cord blood, the placenta and your baby's cord blood will be discarded according to the hospital's standard practice.

Alternately, there are companies that you can pay to store cord blood for future family use. These companies, including Cryobanks, will collect, process, and store the cord blood. Arrangements generally need to be made in advance of your delivery and there is a charge for these services.

VIII. REIMBURSEMENT AND COSTS

Neither you nor your baby will be paid for donating cord blood or for participating in this study. Ultimately, people who receive the cord blood unit for transplantation may pay for the cord blood unit, or their medical insurance companies may pay for the cord blood unit. Cord blood units, which are used for other types of research, may be paid for by the research institution. There are no plans to pass the payment on to you or your baby.

The cord blood bank will pay for the cord blood collection and all associated costs. You will not be charged by the cord blood bank for any expenses resulting from the donation of the cord blood. It is important for you to verify that your physician will not charge you for collection of the cord blood. Physician charges to you are not reimbursable by Cryobanks. Your insurance company will not be charged for anything associated with the study. You will not be charged for any aspect of participating in this research study.

IX. QUESTIONS OR CONCERNS

If you need more information about this study before you decide to join, the person in charge of this study at the cord blood bank is Donald Hudspeth, at 1-800-869-8608.

If you have any questions or concerns about your rights as a research subject or about the potential risks or injuries, please contact Roberta King, IRB Administrator, at the National Marrow Donor Program at 1-800-526-7809.

If you have any questions or concerns about your relationship with your cord blood bank you may contact the cord blood bank investigator Dr. John Edwards, at 1-800-869-8608.

X. STATEMENT OF CONSENT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS CONSENT FORM, YOU HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS, AND YOU AGREE TO DONATE YOUR BABY'S CORD BLOOD FOR CORD BLOOD BANKING AND TRANSPLANTATION RESEARCH.

Signature of the Mother on behalf of her baby as Donor/Subject

Date

Print Name of Mother

<p><i>NATIONAL MARROW DONOR PROGRAM® INSTITUTIONAL REVIEW BOARD</i></p> <p>CONSENT FORM APPROVAL DATE: July 1, 2007 – June 30, 2008</p> <p>Do not sign this form after the Expiration date of: June 30, 2008</p>
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<p>Use of an Interpreter: Complete if the subject is not fluent in English and an interpreter was used to obtain consent.</p> <p>Print name of interpreter: _____ Date: _____</p> <p>Signature of interpreter: _____ Date: _____</p> <p>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 addendum for documentation.</p>

<p>[TO BE COMPLETED BY CRYOBANKS STAFF ONLY]</p> <p>Certification of Counseling Healthcare Professional</p> <p>I certify that the nature and purpose, the potential benefits, and possible risks associated with this research study have been explained to the above individual and that any questions about this information have been answered.</p> <p>_____ <i>Counseling Healthcare Professional</i></p> <p>_____ <i>Date</i></p>
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CRYOBANKS INTERNATIONAL, INC. - DONOR INFORMATION

BABY'S MOTHER'S NAME: _____		SS#: _____ (Optional)
ADDRESS: _____		APT#: _____
CITY: _____	STATE: _____	ZIP CODE: _____
HOME PHONE: _____	WORK PHONE: _____	E-MAIL: _____
BABY'S MOTHER'S BIRTHDATE: _____		BABY'S DUE DATE: _____

BABY'S FATHER'S NAME: _____		SS#: _____ (Optional)
ADDRESS: _____		APT#: _____
CITY: _____	STATE: _____	ZIP CODE: _____
BABY'S FATHER'S BIRTHDATE: _____		

PHYSICIAN & HOSPITAL INFORMATION

PHYSICIAN NAME: _____		
CLINIC NAME: _____	PHONE: _____	
CLINIC ADDRESS: _____	SUITE: _____	
CITY: _____	STATE: _____	ZIP CODE: _____
HOSPITAL FOR DELIVERY: _____		
HOSPITAL ADDRESS: _____	PHONE: _____	
CITY: _____	STATE: _____	ZIP CODE: _____

RACIAL/ETHNIC BACKGROUND:

Please describe the ethnicity of the baby's mother (M) and father (F). Check all that apply.

<p>M E Caucasian/White:</p> <input type="checkbox"/> <input type="checkbox"/> North American (CAU) <input type="checkbox"/> <input type="checkbox"/> Northern European (CAU) <input type="checkbox"/> <input type="checkbox"/> Western European (CAU) <input type="checkbox"/> <input type="checkbox"/> Eastern European (CAU) <input type="checkbox"/> <input type="checkbox"/> White South or Central American (CAU) <input type="checkbox"/> <input type="checkbox"/> White Caribbean (CAU) <input type="checkbox"/> <input type="checkbox"/> Mediterranean (CAU) <input type="checkbox"/> <input type="checkbox"/> Middle Eastern (MENAFC) <input type="checkbox"/> <input type="checkbox"/> North Coast of Africa (MENAFC) <input type="checkbox"/> <input type="checkbox"/> White (not otherwise specified) (CAU) <p>M E Hispanic:</p> <input type="checkbox"/> <input type="checkbox"/> Mexican or American Hispanic (MSWHIS) <input type="checkbox"/> <input type="checkbox"/> South/Central American Hispanic (SCAHIS) <input type="checkbox"/> <input type="checkbox"/> Caribbean Hispanic (CARHIS) <input type="checkbox"/> <input type="checkbox"/> Hispanic (not otherwise specified) (HIS)	<p>M E Black:</p> <input type="checkbox"/> <input type="checkbox"/> African American (AAFA) <input type="checkbox"/> <input type="checkbox"/> African Black (born in Africa) (AFB) <input type="checkbox"/> <input type="checkbox"/> Caribbean Black (CARB) <input type="checkbox"/> <input type="checkbox"/> South or Central American Black (SCAMB) <input type="checkbox"/> <input type="checkbox"/> Black (not otherwise specified) (AFA) <p>M E Native American:</p> <input type="checkbox"/> <input type="checkbox"/> Native American: (AMIND) Tribe: _____ <input type="checkbox"/> <input type="checkbox"/> Native Alaskan/Aleut: (ALANAM) Tribe: _____ <input type="checkbox"/> <input type="checkbox"/> American Indian South or Central American (AMIND) <input type="checkbox"/> <input type="checkbox"/> Caribbean Indian (AMIND)	<p>M E Asian/Pacific Islander:</p> <input type="checkbox"/> <input type="checkbox"/> Japanese (JAPI) <input type="checkbox"/> <input type="checkbox"/> Korean (KORI) <input type="checkbox"/> <input type="checkbox"/> Chinese (NCHI) <input type="checkbox"/> <input type="checkbox"/> Asian Indian (AINDI) <input type="checkbox"/> <input type="checkbox"/> Vietnamese (SCSEAI) <input type="checkbox"/> <input type="checkbox"/> South Asian (SCSEAI) <input type="checkbox"/> <input type="checkbox"/> Southeast Asian (SCSEAI) <input type="checkbox"/> <input type="checkbox"/> Filipino (FILI) <input type="checkbox"/> <input type="checkbox"/> Hawaiian (Polynesian)(HAWI) <input type="checkbox"/> <input type="checkbox"/> Guamanian (OPI) <input type="checkbox"/> <input type="checkbox"/> Samoan (OPI) <input type="checkbox"/> <input type="checkbox"/> Other Asian/Pacific Islander (not otherwise specified) (OPI) <p>M E Other (Specify): (OTH)</p> <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> Unknown (UNK)
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Please read the following Health Questionnaire carefully. You may contact Cryobanks International, Inc. if you need help understanding any of the questions. Our toll-free number is 1-800-869-8608.

Completion of the health questionnaire is required before a cord blood unit can be eligible for use. 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 Cryobanks International's 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 Cryobanks International: 1-800-869-8608 outside of the Orlando area, or 407-834-8333 in the Orlando area. You will not be penalized from withdrawing from the program at any time. All information you provide is kept private and confidential.

CRYOBANKS INTERNATIONAL, INC. – HEALTH QUESTIONNAIRE

EXPECTANT MOTHER: _____ DATE OF BIRTH (OPTIONAL): _____

Cord Blood Maternal Questions

Please read carefully and answer the following questions. Mark "Y" for "YES" or "N" for "NO".

1.	Have you ever donated or attempted to donate cord blood using your current or a different name to this cord blood bank?	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? If yes, why? _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
3.	Have you taken any of the following medications (check all that apply): a. <input type="checkbox"/> Hepatitis B Immune Globulin (HBIG) in the last 12 months? b. <input type="checkbox"/> Insulin from cows (bovine or beef insulin) since 1980? c. <input type="checkbox"/> Growth hormone from human pituitary glands ever? d. <input type="checkbox"/> Hepatitis B Vaccine ever?	Y <input type="checkbox"/>	N <input type="checkbox"/>
4.	In the past 12 weeks , have you had any shots or vaccinations? If yes, please describe _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
5.	In the past 8 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)	Y <input type="checkbox"/>	N <input type="checkbox"/>
6.	In the past 4 months , have you experienced two 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? If yes , which symptoms and when? Please specify: _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
7.	In the past 12 months , have you had a major illness or surgery? If yes , please describe: _____ _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
8.	Have you ever had any type of cancer, including leukemia? If yes , please describe: _____ _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
9.	Have you ever had a bleeding condition or blood disease, including sickle cell disease? If yes , please specify: _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
10.	Have you ever had a bleeding problem, such as hemophilia or other clotting factor deficiencies, and received human-derived clotting factor concentrates? If yes , please specify: _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
11.	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"/>
12.	Have you ever had yellow jaundice, liver disease, viral hepatitis, or a positive test (including screening tests) for hepatitis? If yes , please describe and include dates: _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
13.	Have you ever had a parasitic blood disease such as Chagas' disease or Babesiosis?	Y <input type="checkbox"/>	N <input type="checkbox"/>
14.	Have you ever been diagnosed with Creutzfeldt-Jakob Disease (CJD) or variant CJD or do you have a degenerative neurological condition such as dementia where the cause has not been identified?	Y <input type="checkbox"/>	N <input type="checkbox"/>
15.	Have any of your blood relatives ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), or have you been told that your family has an increase risk for CJD?	Y <input type="checkbox"/>	N <input type="checkbox"/>
16.	Have you received a dura mater (brain covering) graft?	Y <input type="checkbox"/>	N <input type="checkbox"/>
17.	Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal ?	Y <input type="checkbox"/>	N <input type="checkbox"/>
18.	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 ?	Y <input type="checkbox"/>	N <input type="checkbox"/>
19.	In the past 3 years , have you had malaria?	Y <input type="checkbox"/>	N <input type="checkbox"/>
20.	In the past 3 years , have you been outside the United States or Canada? If yes , please list where, when, and for how long: _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
21.	In the past 12 months , have you had a blood transfusion?	Y <input type="checkbox"/>	N <input type="checkbox"/>

CRYOBANKS INTERNATIONAL, INC. - HEALTH QUESTIONNAIRE

EXPECTANT MOTHER: _____ DATE OF BIRTH (OPTIONAL): _____

22.	In the past 12 months, have you had a transplant such as organ, bone marrow, stem cell, cornea, bone or other tissue?	Y <input type="checkbox"/>	N <input type="checkbox"/>
23.	In the past 12 months, have you had a tissue graft such as bone or skin?	Y <input type="checkbox"/>	N <input type="checkbox"/>
24.	In the past 12 months, have you had a tattoo? If yes , answer question 25. If no , skip to question 26	Y <input type="checkbox"/>	N <input type="checkbox"/>
	25. If yes , were shared instruments, needles, or inks used for the tattoo?	Y <input type="checkbox"/>	N <input type="checkbox"/>
26.	In the past 12 months, have you had an ear, skin, or body piercing using shared instruments or needles?	Y <input type="checkbox"/>	N <input type="checkbox"/>
27.	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) ?	Y <input type="checkbox"/>	N <input type="checkbox"/>
28.	In the past 12 months, have you had or been treated for a sexually transmitted disease, including syphilis? If yes , please describe and include dates: _____	Y <input type="checkbox"/>	N <input type="checkbox"/>
29.	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"/>
30.	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 <u>past 5 years</u> ?	Y <input type="checkbox"/>	N <input type="checkbox"/>
31.	In the past 12 months, have you had sexual contact or lived with a person who has active or chronic viral hepatitis or yellow jaundice?	Y <input type="checkbox"/>	N <input type="checkbox"/>
32.	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 <u>past 5 years</u> ?	Y <input type="checkbox"/>	N <input type="checkbox"/>
33.	In the past 12 months, have you had sex with a male who has had sex with another male, even once, in the <u>past 5 years</u> ?	Y <input type="checkbox"/>	N <input type="checkbox"/>
34.	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 <input type="checkbox"/>	N <input type="checkbox"/>
35.	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"/>
36.	In the past 12 months, have you been in juvenile detention, lockup, jail or prison for more than 72 continuous hours?	Y <input type="checkbox"/>	N <input type="checkbox"/>
37.	In the past 5 years have you received money, drugs, or other payment for sex?	Y <input type="checkbox"/>	N <input type="checkbox"/>
38.	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"/>
39.	Do you have AIDS or have you ever tested positive for HIV (including screening tests)?	Y <input type="checkbox"/>	N <input type="checkbox"/>
40.	Do you have any of the following:		
	40A. Unexplained night sweats?	Y <input type="checkbox"/>	N <input type="checkbox"/>
	40B. Unexplained blue or purple spots on or under the skin or mucous membranes?	Y <input type="checkbox"/>	N <input type="checkbox"/>
	40C. Unexplained weight loss?	Y <input type="checkbox"/>	N <input type="checkbox"/>
	40D. Unexplained persistent diarrhea?	Y <input type="checkbox"/>	N <input type="checkbox"/>
	40E. Unexplained cough or shortness of breath?	Y <input type="checkbox"/>	N <input type="checkbox"/>
	40F. Unexplained temperature higher than 100.5°F (38.6°C) for more than 10 days?	Y <input type="checkbox"/>	N <input type="checkbox"/>
	40G. Unexplained persistent white spots or sores in the mouth?	Y <input type="checkbox"/>	N <input type="checkbox"/>
	40H. Lumps in your neck, armpits, or groin lasting longer than one month?	Y <input type="checkbox"/>	N <input type="checkbox"/>
41.	Have you ever tested positive for HTLV (including screening tests)?	Y <input type="checkbox"/>	N <input type="checkbox"/>
42.	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 <input type="checkbox"/>	N <input type="checkbox"/>

CRYOBANKS INTERNATIONAL, INC. - HEALTH QUESTIONNAIRE

EXPECTANT MOTHER: _____ DATE OF BIRTH (OPTIONAL): _____

For Questions 43 through 52, please refer to the chart below for a list of countries involved:

Reference Guide for Questions 43 & 46: Countries defined as Europe

Albania	Germany	Norway	Switzerland
Austria	Greece	Poland	Turkey
Belgium	Hungary	Portugal	United Kingdom (UK) includes:
Bosnia-Herzegovina	Ireland (Republic of)	Romania	England, Northern Ireland
Bulgaria	Italy	San Marino	Scotland, Wales, the Isle of Man,
Croatia	Liechtenstein	Slovak Republic	the Channel Islands, Gibraltar
Czech Republic	Luxembourg	Slovenia	or Falkland Islands
Denmark	Macedonia	Spain	Yugoslavia (federal republic of)
Finland	Netherlands (Holland)	Sweden	Kosovo, Montenegro, Serbia
France			

Reference Guide for Questions 50-52: African Countries

Cameroon	Chad	Equatorial Guinea	Niger
Central African Republic	Congo	Gabon	Nigeria

43. Since 1980, have you ever lived in or traveled to Europe? (refer to chart above) If yes , answer questions 44 through 46. If no , skip to question 47	Y <input type="checkbox"/>	N <input type="checkbox"/>
44. 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 <input type="checkbox"/>	N <input type="checkbox"/>
45. Since 1980, have you received a transfusion of blood or blood components while in the UK or France?	Y <input type="checkbox"/>	N <input type="checkbox"/>
46. 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 <input type="checkbox"/>	N <input type="checkbox"/>
47. 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? If yes , answer 48 and 49. If no , skip to question 50	Y <input type="checkbox"/>	N <input type="checkbox"/>
48. 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: UK, Belgium, Netherlands or Germany?	Y <input type="checkbox"/>	N <input type="checkbox"/>
49. 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 <input type="checkbox"/>	N <input type="checkbox"/>
50. Since 1977, were you born in, have you lived in, or have you traveled to any African country listed above? If yes , answer question 51. If no , skip to question 52	Y <input type="checkbox"/>	N <input type="checkbox"/>
51. 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"/>
52. Have you had sexual contact with anyone who was born in or lived in any African country listed above since 1977?	Y <input type="checkbox"/>	N <input type="checkbox"/>
53. Were you and/or the baby's father adopted at early childhood?	Y <input type="checkbox"/>	N <input type="checkbox"/>
53A. If yes , is a family medical history available for you and/or the baby's father?	Y <input type="checkbox"/>	N <input type="checkbox"/>
54. Are you and the baby's father related, except by marriage? (e.g. first cousins)	Y <input type="checkbox"/>	N <input type="checkbox"/>
55. Did this pregnancy use either a donor egg or donor sperm?	Y <input type="checkbox"/>	N <input type="checkbox"/>
55A. 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"/>
56. 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 57	Y <input type="checkbox"/>	N <input type="checkbox"/>
56A. Which test was abnormal? _____		
56B. What was the abnormal test result? _____		
56C. Was a diagnosis made? Specify diagnosis: _____		
57. Have you had any children who died within the first 10 years of life?	Y <input type="checkbox"/>	N <input type="checkbox"/>
57A. If yes , what was the cause? _____		
58. Have you ever had a stillborn child?	Y <input type="checkbox"/>	N <input type="checkbox"/>
58A. If yes , what was the cause? _____		

CRYOBANKS INTERNATIONAL, INC. - HEALTH QUESTIONNAIRE

EXPECTANT MOTHER: _____ DATE OF BIRTH (OPTIONAL): _____

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' siblings (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.)

59. Cancer or Leukemia? Y <input type="checkbox"/> N <input type="checkbox"/>	BM	BF	BS	
If yes, please specify all that apply in 59A-59J. If no, skip to question 58.				
59A. Brain or other nervous system cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59B. Bone or joint cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59C. Kidney (including renal pelvic) cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59D. Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59E. Hodgkin's Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59F. Non-Hodgkin's Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59G. Acute or chronic myelogenous/myeloid leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59H. Acute or chronic lymphocytic/lymphoblastic leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59I. Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59J. Other cancer/leukemia				
Specify Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Type: _____				

Answer Questions 60-64 for any Blood disorders or Diseases. **If yes**, please specify as applicable.

60. Red Blood Cell Disease? Y <input type="checkbox"/> N <input type="checkbox"/>	BM	BF	BS	BGP	BMS	BFS
If yes, please specify all that apply in 60A-60J. If no, skip to question 61.						
60A. Diamond-Blackfan Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60B. Elliptocytosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60C. 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"/>
60D. Spherocytosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. White Blood Cell Disease? Y <input type="checkbox"/> N <input type="checkbox"/>	BM	BF	BS	BGP	BMS	BFS
If yes, please specify all that apply in 61A-61D. If no, skip to question 62.						
61A. Chronic Granulomatous Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61B. Kostmann Syndrome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61C. Schwachman-Diamond Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61D. Leukocyte Adhesion Deficiency (LAD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Immune Deficiencies? Y <input type="checkbox"/> N <input type="checkbox"/>	BM	BF	BS	BGP	BMS	BFS
If yes, please specify all that apply in 62A-62H. If no, skip to question 63.						
62A. ADA or PNP Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62B. 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"/>
62C. DiGeorge Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62D. Hereditary Hemophagocytic Lymphohistiocytosis (HLH) including FEL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62E. Hypoglobulinemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62F. Nezeloff Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62G. Severe Combined Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62H. Wiskott-Aldrich Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CRYOBANKS INTERNATIONAL, INC. - HEALTH QUESTIONNAIRE

EXPECTANT MOTHER: _____ DATE OF BIRTH (OPTIONAL): _____

63. Platelet Disease? Y <input type="checkbox"/> N <input type="checkbox"/>		BM	BF	BS	BGP	BMS	BFS
If yes, please specify all that apply in 63A-63G. If no, skip to question 64.							
63A. Amegakaryocytic Thrombocytopenia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63B. Glanzmann Thrombasthenia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63C. Hereditary Thrombocytopenia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63D. Platelet Storage Pool Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63E. Thrombocytopenia with absent radii (TAR)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63F. Ataxia-Telangiectasia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63G. Fanconi Anemia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. Other blood disease or disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: _____							
Hemoglobin Problems		BM	BF	BS	BGP	BMS	BFS
65.	Sickle cell disease, such as sickle-cell anemia or Sickle thalassemia? Y <input type="checkbox"/> N <input type="checkbox"/> Specify disease: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66.	Thalassemia, such as alpha thalassemia or beta-thalassemia? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. Metabolic/Storage Disease? Y <input type="checkbox"/> N <input type="checkbox"/>		BM	BF	BS	BGP	BMS	BFS
If yes, please specify all that apply in 67A-67Q. If no, skip to question 68.							
67A. Hurler Syndrome (MPS I)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67B. 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"/>
67C. Hunter Syndrome (MPS II)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67D. Sanfilippo Syndrome (MPS III)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67E. Morquio Syndrome (MPS IV)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67F. Maroteaux-Lamy Syndrome (MPS VI)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67G. Sly Syndrome (MPS VII)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67H. I-cell disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67I. Globoid Leukodystrophy (Krabbe Disease)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67J. Metachromatic Leukodystrophy (MLD).....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67K. Adrenoleukodystrophy (ALD)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67L. Sandhoff Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67M. Tay-Sachs Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67N. Gaucher Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67O. Niemann Pick-Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67P. Porphyria		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67Q. Other or unknown metabolic/storage disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acquired Immune System Disorders		BM	BF	BS			
68.	HIV/AIDS? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
69.	Severe autoimmune disorder? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, please specify all that apply in questions 69A-69D. If no, skip to question 70.		BM					
69A. Crohn's Disease or Ulcerative Colitis		<input type="checkbox"/>					
69B. Lupus		<input type="checkbox"/>					
69C. Multiple Sclerosis (MS)		<input type="checkbox"/>					
69D. Rheumatoid Arthritis		<input type="checkbox"/>					
70.	Any other or unknown immune system disorder? Y <input type="checkbox"/> N <input type="checkbox"/>	BM	BF	BS			
Specify Disorder: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

CRYOBANKS INTERNATIONAL, INC. - HEALTH QUESTIONNAIRE

EXPECTANT MOTHER: _____ DATE OF BIRTH (OPTIONAL): _____

Answer Questions 71-77		BM	BF	BS	BGP	BMS	BFS
71.	Required Chronic Blood Transfusions? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72.	Been told you or your family member(s) have hemolytic anemia? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73.	Had spleen removed to treat a blood disorder? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74.	Had gallbladder removed before the age of 30? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.	Had Creutzfeldt-Jakob disease (CJD)? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76.	Other serious or life-threatening diseases affecting the family? Y <input type="checkbox"/> N <input type="checkbox"/> If yes , list affected family member(s) and type of disease Specify Type: _____ Specify Type: _____ Specify Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
77.	In answering these questions, have you answered for both your family and the baby's father's family? Y <input type="checkbox"/> N <input type="checkbox"/>						

Addendum: 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 <input type="checkbox"/>	N <input type="checkbox"/>
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 <input type="checkbox"/>	N <input type="checkbox"/>
3.	In the past 14 days, have you traveled outside of the United States?	Y <input type="checkbox"/>	N <input type="checkbox"/>
4.	In the past 14 days, has someone you live with traveled to, traveled through, or resided in areas affected by SARS?	Y <input type="checkbox"/>	N <input type="checkbox"/>
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 <input type="checkbox"/>	N <input type="checkbox"/>

To be completed by Cord Blood Bank Staff: N/A Person-to-person transmission of SARS not occurring.

EXPECTANT MOTHER SIGNATURE: _____ DATE: _____

Signing for pages 1-7

CRYOBANKS INTERNATIONAL, INC.

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 Cryobanks International, Inc., 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 Cryobanks International, Inc., for processing and placement into storage.

My physician, physician's designee, or midwife 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 Cryobanks International, Inc. 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.

PHYSICIAN - DONATED SAMPLE

My patient desires the collection of her unborn's cord blood for donation to Cryobanks International, Inc. 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 Cryobanks International, Inc. for processing and placement into storage.

I will perform the collection of the cord blood after the birth of her baby, while the delivery of the placenta occurs. I will use the methods provided by Cryobanks International, Inc. in their standard operational procedures. The collection period will be brief and Cryobanks International, Inc. will provide the protocols and collection equipment in the kit. I will utilize my best efforts 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 Cryobanks International, Inc. 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.

Cryobanks International, Inc., 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.

Signature of Expectant Mother Date

Signature of Physician or Midwife Date

Print Name (Expectant Mother)

Print Name (Physician or Midwife)

THIS PAGE IS REQUIRED TO BE SIGNED BY YOU AND YOUR PHYSICIAN/MIDWIFE IN ORDER TO RECEIVE A CRYOBANKS INTERNATIONAL 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.

CRYOBANKS INTERNATIONAL, INC.

INFORMED CONSENT FOR THE HIV TEST

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.

CONSENT	PHYSICIAN'S ORDER FOR BLOOD TESTING
<p>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 Cryobanks International, Inc. to report any positive HIV test result to the County Health Department.</p> <p>I have read the above information and have had my questions about the test answered. I agree to take the HIV test. I allow the test results to be made available to Cryobanks International, Inc. and to my private physician, Dr. _____.</p>	<div style="text-align: center;"> Patient: _____ </div> <div style="text-align: center; margin-top: 10px;"> </div> <p style="text-align: center;">It is an FDA requirement that Cryobanks International performs maternal blood testing.</p> <p style="text-align: center;">Tubes will be included with the cord blood collection kit to be drawn at the hospital/birthing center during labor and delivery.</p> <p>ORDER: Maternal Blood Draw for:</p> <ul style="list-style-type: none"> HIV-1 and HIV-2 (antibody to the AIDS virus) HCV/HIV NAT (Hep. C and AIDS virus by Nucleic Acid Test) HEPATITIS B (HBsAg & HBcAb) HEPATITIS C VIRUS (Anti-HCV) HTLV-I and HTLV-II SYPHILIS, CMV, ABO Rh WNV
<p>_____ Signature of Expectant Mother Date</p> <p>_____ Print Name (Expectant Mother)</p>	<p>_____ Signature of Physician or Midwife Date</p> <p>_____ Print Name (Physician or Midwife)</p>

THIS PAGE IS REQUIRED TO BE SIGNED BY YOU AND YOUR PHYSICIAN/MIDWIFE IN ORDER TO RECEIVE A CRYOBANKS INTERNATIONAL 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 Inquiry Form

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. As a member cord blood bank of the National Marrow Donor Program and being Accredited by the AABB, we must ensure in every way possible that the collection process is as successful as possible. A quality collection is the biggest predictor in converting a donated sample to a transplantable product.

To ensure a high quality, high volume sample, we would like to offer you, at no cost, collection training materials for you to self-train in the collection procedure. The space below allows you to choose any/all materials that you feel would be useful. 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. She will bring this kit to the hospital/birthing center at the time of delivery/collection.

We appreciate your willingness to help your patient provide this potentially life-saving donation to the common good. We understand that your time in this process is of the utmost importance. Without your efforts, we would not be able to meet the increasing demands for stem cell transplants around the world.

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I have collected umbilical cord blood several times before, and am comfortable with the procedure. I do not require/desire additional training material(s).

I would like the following materials to enhance my collection technique(s):

- Pocket-sized, full-color collection booklet
- NMDP collection video on CD-ROM (for laptops, computers only)
- NMDP collection video on DVD (for computers and/or TV-attached DVD players)

I would like ____ additional copies for other staff members. (5 maximum per request)

Please send materials to the following address:

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For Cryobanks staff:

Date materials sent: _____