

BABY'S RACE AND ETHNICITY INFORMATION

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

BABY'S ETHNICITY:

RESPONSE IS REQUIRED, PLEASE CHECK ONE: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

BABY'S RACE:

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)

Native Hawaiian or Other Pacific Islander

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

Black or African American

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

White

- ☐ Eastern European (CAU) ☐ Northern European (CAU)
- ☐ Mediterranean (CAU) ☐ Western European (CAU)
- ☐ Middle Eastern (MENAF) ☐ White Caribbean (CAU)
- ☐ North Coast of Africa (MENAF) ☐ White South or Central American (CAU)
- ☐ North American (CAU) ☐ Other White (CAU)

Asian

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

SIGNATURE

I have received information from the cord blood bank necessary to complete the following forms:

- Maternal Demographic Information
- Maternal Risk Questionnaire
- Family Medical History Questionnaire

I have completed these forms to the best of my knowledge. I understand that only authorized staff from the cord blood bank will have access to my personal information.

Forms completed by:

Signature

Today's Date: _____

Thank you for donating your baby's cord blood. The blood in the umbilical cord and placenta is unique because it contains a large number of blood-forming cells. Seriously ill patients, whose bodies cannot make healthy cells of their own, can be helped by a donation of healthy cord blood cells from a matched unit. Cord blood donations give more patients hope of finding a match.

In the event that an illness affecting the immune system or a blood related disease should develop in your baby, or if you learn of a reason which would exclude you from donating or feel that it should not be transfused to a patient, please call Celebration Stem Cell Centre: (480) 722-9963 or toll-free at 1-877-522-2355.

MATERNAL RISK AND FAMILY MEDICAL HISTORY QUESTIONNAIRE
MATERNAL RISK QUESTIONNAIRE

Please read carefully and answer the following questions "YES" or "NO".

1.	Have you ever donated or attempted to donate cord blood using your current or a different name to this cord blood bank?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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? <i>If yes, why?</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Are you know taking or have you ever taken any of the following medications? (check all that apply): a. Insulin from cows (bovine or beef insulin)?..... b. Growth hormone from human pituitary glands ever?..... c. Rabies vaccination in the past year?..... d. Hepatitis B Immune Globulin?..... e. Unlicensed Vaccine?.....	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
4.	Are you currently taking an antibiotic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Are you currently taking any other medication for an infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	In the past 8 weeks , have you had any vaccinations or other shots? <i>If yes</i> , please describe: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	In the past 12 weeks , have you had contact with someone who had a smallpox vaccine?..... (Examples of contact include physical intimacy, touching the vaccination site, touching the bandages or covering of the vaccination site, or handling bedding or clothing that had been in contact with an unbandaged vaccination site.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	In the past 4 months , have you experienced two (2) or more of the following: a fever (>100.5°F or 38.06°C), headache, muscle weakness, skin rash on trunk of the body, or swollen lymph glands? <i>If yes</i> , which symptoms and when? Please specify: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Have you ever had any type of cancer, including leukemia?..... <i>If yes</i> , please describe: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	In the past 12 months , have you been told by a healthcare professional that you have West Nile Virus infection or received any positive test for West Nile Virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Have you ever had a diagnosis of clinical, symptomatic viral hepatitis after age 11?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Have you ever had a parasitic blood disease (for example, Leishmaniasis, Babesiosis, Chagas disease) or any positive tests for Chagas or T. cruzi, including screening tests?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Have you ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), variant CJD, dementia, any degenerative or demyelinating disease of the central nervous system, or other neurological disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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 increased risk for CJD?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Have you received a dura mater (brain covering) graft?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	In the past 3 years:		
19.	Have you had malaria?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20.	Have you been outside the United States or Canada?..... <i>If yes, please list where, when, and for how long: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21.	In the 12 months prior to the collection of the cord blood unit, have you had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	In the past 12 months:		
22.	Have you had a transplant or tissue graft from someone else such as organ, bone marrow, stem cell, cornea, bone, skin, or other tissue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23.	Have you had a tattoo or ear, skin, or body piercing?..... If yes, answer question 22. If no, skip to question 23.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24.	Were shared or non-sterile inks, needles, instruments, or procedures used for the tattoo or piercing?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25.	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.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26.	Have you had or been treated for a sexually transmitted disease, including syphilis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27.	Have you given money or drugs to anyone to engage in sex with you?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28.	Have you engaged in sex with anyone who had taken money or drugs for sex in the past 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29.	Have you had sexual contact or lived with a person who has active or chronic viral Hepatitis B or Hepatitis C?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30.	Have you had sex, even once, with anyone who has used a needle to take drugs, steroids, or anything else <u>not</u> prescribed by a doctor in the past 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31.	Have you had sex with a male who has had sex with another male, even once, in the past 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32.	Have you had sex, even once, with anyone who has taken human-derived clotting factors for a bleeding problem in the past 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33.	Have you had sex, even once, with anyone who has HIV/AIDS or had a positive test for the AIDS virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
34.	Have you been in juvenile detention, lockup, jail or prison for more than 72 continuous hours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	In the past 5 years:		
35.	Have you engaged in sex in exchange for money or drugs?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
36.	Have you used a needle, even once, to take drugs, steroids or anything else <u>not</u> prescribed for you by a doctor?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
37.	Do you have AIDS or have you ever tested positive for HIV (including screening tests)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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38.	Do you have any of the following:						
	38a. Unexplained night sweats?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38b. Unexplained blue or purple spots on or under the skin or mucous membrane?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38c. Unexplained weight loss?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38d. Unexplained persistent diarrhea?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38e. Unexplained cough or shortness of breath?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38f. Unexplained temperature higher than 100.5°F (38.06°C) for more than 10 days?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38g. Unexplained persistent white spots or sores in the mouth?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38h. Multiple lumps in your neck, armpits, or groin lasting longer than one month?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	38i. Any infections during your pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
39.	Have you ever tested positive for HTLV (including screening tests) or had unexplained paraparesis (partial paralysis affecting the lower limbs)? HTLV refers to Human T-cell Lymphotropic Virus.					<input type="checkbox"/> Yes	<input type="checkbox"/> No
40.	If a person has the AIDS virus, do you understand that the person <u>can give it to someone else</u> even though they may feel well and have a negative AIDS test?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
For Questions 41 through 50 please refer to the charts below for a list of countries involved:							
Albania	France	Netherlands (Holland)	Switzerland	Yugoslavia (Federal Republic of)			
Austria	Germany	Norway	United Kingdom (UK)	Kosovo			
Belgium	Greece	Poland	England	Montenegro			
Bosnia-Herzegovina	Hungary	Portugal	Northern Ireland	Serbia			
Bulgaria	Ireland (Republic of)	Romania	Scotland, Wales				
Croatia	Italy	Slovak Republic	The Isle of Man				
Czech Republic	Liechtenstein	Slovenia	The Channel Islands				
Denmark	Luxembourg	Spain	Gibraltar				
Finland	Macedonia	Sweden	The Falkland Islands				
41.	Since 1980, have you ever lived in or traveled to Europe? (refer to chart above). If yes, answer questions 42 through 45. If no, skip question 48.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No
42.	From 1980 through 1996, did you spend time that adds up to 3 months or more in the United Kingdom (refer to chart above)?.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No
43.	Since 1980, have you received a transfusion of blood or blood components while in the UK or France?.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No
44.	Since 1980, have you spent time that adds up to 5 years or more in Europe (refer to chart above), including time spent in UK between 1980 and 1996?.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No
45.	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 or civilian military employee? If yes, answer 46 and 47. If no, skip to question 48.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No
46.	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?.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.	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?.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reference Guide for Questions 46 – 48: African Countries							
Benin	Central African Republic	Congo	Gabon	Niger	Senegal	Zambia	
Cameroon	Chad	Equatorial Guinea	Kenya	Nigeria	Togo		
48.	Since 1977, were you born in, have you lived in, or have you traveled to any African country listed above?.....					<input type="checkbox"/> Yes	<input type="checkbox"/> No

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If yes, answer question 49. If no, skip to question 50.			
49. 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?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
50. Have you had sexual contact with anyone who was born in or lived in any African country listed above since 1977 ?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

FAMILY MEDICAL HISTORY QUESTIONNAIRE

1.	Were you and/or the baby's father adopted at early childhood?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1a.	If yes , is a family medical history available for you and/or the baby's father?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Are you and the baby's father related, except by marriage? (e.g. first cousins)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Did this pregnancy either use a donor egg or donor sperm?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3a.	If yes , is a family medical history questionnaire available for the egg or sperm donor? (please attach copy).....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	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 questions 5.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4a.	Which test was abnormal?.....		
4b.	What was the abnormal test result?.....		
4c.	Was a diagnosis made?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes , specify diagnosis:.....		
5.	Have you had any children who died within the first 10 years of life?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5a.	If yes , what was the cause?.....		
6.	Have you ever had a stillborn child?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6a.	If yes , what was the cause?.....		

For the remainder of the questionnaire, describe the relationship between the baby and the immediate family member with the disease. Please refer to the following codes:

Family Relationship Codes: **BM** Baby's Mother **BGP** Baby's Grandparent **BMS** Baby's Mother's Sibling*
BF Baby's Father **BS** Baby's sibling **BFS** Baby's Father's Sibling *

*(Parent's 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).

7.	Cancer or Leukemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If yes , please specify all that apply in 7A-7I . If no , skip to question 8.		BM	BF	BS	IMMEDIATE FAMILY ONLY	
7a.	Brain or other nervous system cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7b.	Bone or joint cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7c.	Kidney (including renal pelvic) cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7d.	Thyroid Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7e.	Hodgkin's Lymphoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7f.	Non-Hodgkin's Lymphoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7g.	Acute or chronic myelogenous/myeloid leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7h.	Acute or chronic lymphocytic/lymphoblastic leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7i.	Skin Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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7j. Other cancer/leukemia.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Specify Type: _____						
Specify Type: _____						
Answer Questions 8-12 for any Blood Disorders or Diseases. <i>If yes</i> , please specify as applicable.						
8.	Red Blood Cell Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<i>If yes</i> , please specify that all apply in 8a-8d. If no, skip to question 9.				BM	BF	BS
				BGP	BMS	BFS
8a.. Diamond-Blackfan Syndrome.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8b. Elliptocytosis.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8c. Spherocytosis.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8d. G6PD or other red cell enzyme deficiency.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	White Blood Cell Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<i>If yes</i> , please specify all that apply in 9a-9d. <i>If no</i> , skip to question 10.				BM	BF	BS
				BGP	BMS	BFS
9a. Chronic Granulomatous Disease.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9b. Kostmann Syndrome.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9c. Schwachman-Diamond Syndrome.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9d. Leukocyte Adhesion Deficiency (LAD).....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Immune Deficiencies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<i>If yes</i> , please specify all that apply in 10a-10h. If no, skip to question 11.				BM	BF	BS
				BGP	BMS	BFS
10a. ADA or PNP Deficiency.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10b. Combined Immunodeficiency Syndrome (CID), Common Variable Immunodeficiency Disease (CVID).....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10c. DiGeorge Syndrome.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10d. Hereditary Hemophagocytic Lymphohistiocytosis (HLH) including FEL.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10e. Hypoglobulinemia.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10f. Nezeloff Syndrome.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10g. Severe Combined Immunodeficiency.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10h. Wiskott-Aldrich Syndrome.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Platelet Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<i>If yes</i> , please specify all that apply in 11a-11g. <i>If no</i> , skip to question 12.				BM	BF	BS
				BGP	BMS	BFS
11a. Amegakaryocytic Thrombocytopenia.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11b. Glanzmann Thrombasthenia.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11c. Hereditary Thrombocytopenia.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11d. Platelet Storage Pool Disease.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11e. Thrombocytopenia with absent radii (TAR).....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11f. Ataxia-Telangiectasia.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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11g.	Fanconi Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Other blood disease or disorder? Specify type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemoglobin Problems			BM	BF	BS	BGP	BMS
13.	Sickle cell disease, such as sickle-cell anemia or sickle thalassemia? Specify disease: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Thalassemia, such as alpha thalassemia or beta-thalassemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Metabolic/Storage Disease? If yes, please specify all that apply in 15a-15q. If no, skip to question 16.	<input type="checkbox"/> Yes <input type="checkbox"/> No	BM	BF	BS	BGP	BMS
			BFS				
15a. Hurler Syndrome (MPS I).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15b. Hurler-Scheie Syndrome (MPS I H-S).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15c. Hunter Syndrome (MPS II).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15d. Sanfilippo Syndrome (MPS III).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15e. Morquio Syndrome (MPS IV).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15f. Maroteaux-Lamy Syndrome (MPS VI).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15g. Sly Syndrome (MPS VII).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15h. I-cell disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15i. Globoid Leukodystrophy (Krabbe Disease).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15j. Metachromatic Leukodystrophy (MLD).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15k. Adrenoleukodystrophy (ALD).....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15l. Sandhoff Disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15m. Tay-Sachs Disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15n. Gaucher Disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15o. Niemann Pick-Disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15p. Porphyria.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15q. Other or unknown metabolic/storage disease..... Specify type: _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acquired Immune System Disorders			BM	BF	BS	IMMEDIATE FAMILY ONLY	
16.	HIV/AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
17.	Severe autoimmune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, please specify all that apply in questions 17a-17d. If no, skip to question 18.			BM	BF	BS		
17a. Crohn's Disease or Ulcerative Colitis.....			<input type="checkbox"/>				
17b. Lupus.....			<input type="checkbox"/>				
17c. Multiple Sclerosis (MS).....			<input type="checkbox"/>				
17d. Rheumatoid Arthritis.....			<input type="checkbox"/>				

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18.	Any other or unknown immune system disorders? Specify Disorder: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Answer Questions 19-25				BM	BF	BS	BGP	BMS	BFS
19.	Required chronic blood transfusions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you been told you or your family member(s) have hemolytic anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Had spleen removed to treat a blood disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Had gallbladder removed before age of 30?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Had Creutzfeldt-Jakob Disease (CJD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Other serious or life-threatening diseases affecting the family?..... <i>If yes</i> , list affected family member(s) and type of disease. Specify Type: _____ Specify Type: _____ Specify Type: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	In answering these questions, have you answered for both your family and the baby's father's family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

Addendum A: Zika Virus

1.	Have you had a medical diagnosis of ZIKV infection at any point during your pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have you resided in, or traveled to, an area with active ZIKV transmission* at any point during your pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you had sex during your pregnancy with a male who is known to have: a. A medical diagnosis of ZIKV within the six months prior to the contact b. Resided in, or traveled to, an area with active ZIKV transmission* within the six months prior to that contact i. Country(ies) traveled to: _____ ii. Date(s) of travel: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Addendum B: Mycobacterium Tuberculosis

1.	Have you ever had a positive test for tuberculosis (TB) infection (including a positive skin test, blood test, or sputum test)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have you ever had a medical diagnosis of TB disease or infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you ever had a diagnosis of latent TB infection (LTBI)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Were you born in an area of the world where TB is common (e.g., Latin American countries, the Caribbean, Africa, Asia, Eastern Europe, Russia)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Have you ever lived in an area of the world where TB is common (e.g., Latin American countries, the Caribbean, Africa, Asia, Eastern Europe, Russia)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MATERNAL RISK AND FAMILY MEDICAL HISTORY QUESTIONNAIRE

6.	Have you ever traveled to an area of the world where TB is common (e.g., Latin American countries, the Caribbean, Africa, Asia, Eastern Europe, Russia)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Have you ever lived in a jail, prison, or correctional facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you ever worked in a jail, prison, or correctional facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Have you ever lived in a long-term care facility, or homeless shelter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Have you ever worked in a long-term care facility, or homeless shelter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Have you ever lived with (resided in the same dwelling) another person who has TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Have you ever been a close contact of another person with TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Do you have a medical condition that can impair your immune function (e.g., diabetes, chronic kidney disease/end stage renal disease with or without dialysis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Are you taking medications that can impair your immune function?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Addendum C: Sepsis			
1.	Do you currently have a medical diagnosis of sepsis or suspicion of sepsis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Consenter Review (if applicable):

Reviewed by: _____ Date: _____

TO BE COMPLETED BY CELEBRATION STEM CELL CENTRE:

I have reviewed the above responses and have determined all requirements met and responses are acceptable: <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, specify reason: _____ Reviewed by: _____ Date: _____ Ineligible Donor Statement: Based on information noted above, this donor is determined to be ineligible to donate her cord blood product. Medical Director, Celebration Stem Cell Centre: _____ Date: _____
