

Indiana Cord Blood Bank (ICBB)

In partnership with The Genesis Bank, LLC

1102 Stadium Drive

Indianapolis, IN 46202

317-917-3462 (p) 317-917-3444 (f)

www.indianacordbloodbank.org

Cord Blood Donor Registration

Thank you for considering registering to donate your baby's umbilical cord blood. The blood in the umbilical cord and placenta is unique because it contains a large number of blood and immune system forming cells. Seriously ill patients whose bodies cannot make health cells of their own can be helped by a donation of healthy blood and immune system forming cells from a matched cord blood unit. Cord blood donations give more patients hope of finding a match. Cord blood units which cannot for any reason be used for transplant will be used in ongoing research to improve the utilization of this valuable resource.

In the event that an illness affecting the immune system or a blood related disease should develop in your baby, please contact the cord blood bank. This may impact a patient receiving the cord blood unit for transplantation.

This packet contains information for you to complete in order to donate your baby's cord blood. Once you have agreed to become a donor and signed the consent forms, you will be asked to answer questions related to you and your family's health. These questions are used in the cord blood bank's evaluation of the cord blood donation to minimize risks to the patient.

For this reason it is important that you carefully read and complete the enclosed forms to the best of your knowledge:

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

These forms can be returned to the bank before your donation, or you may keep them in the kit and return them along with the donated cord blood.

It is also important that your care giver fill out the **Delivery Information Form** after collection of the cord blood, and this form needs to be included as well.

Finally, two weeks after your child is born, please complete the **Follow Up Information Form** and return it in the enclosed pre-addressed and stamped security envelope. If you wish, you may call the cord blood bank directly to satisfy the follow up requirement.

If you have any questions about the forms or cord blood donation, please contact the Indiana Cord Blood Bank at The Genesis Bank LLC, by calling 317-917-3462 or 800-265-0945. You can also email questions to info@thegenesisbank.com.

Indiana Cord Blood Bank- Maternal Questionnaire

Please read questions carefully and answer to the best of your knowledge.

(circle)

1. Have you ever donated or attempted to donate cord blood using your current, or a different name to this cord blood bank? YES 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? YES NO

If yes, why? _____

3. Have you taken any of the following medications (check all that apply): YES NO

- a. Propecia© (finasteride) in the last month?
- b. Accutane© (isotretinoin) in the last month?
- c. Soriatane© (acitretin) in the last 12 months?
- d. Hepatitis B Immune Globulin (HBIG) in the last 12 months?
- e. Insulin from cows (bovine or beef insulin) since 1980?
- f. Tegison© (etretinate) ever?
- g. Growth hormone from human pituitary glands ever?

4. In the past 12 weeks, have you had any shots or vaccinations? YES NO

If yes, please describe: _____

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 of the vaccination site, or handling bedding or clothing that had been in contact with an unbandaged vaccination site.) YES NO

6. In the past 4 weeks, have you experienced two or more of the following: a fever (>100.5F or 38.0°C), headache, muscle weakness, skin rash on trunk of the body, or swollen lymph glands? YES NO

If yes, which symptoms and when? _____

7. In the past 12 months, have you had a major illness or surgery? YES NO

If yes, please describe: _____

8. Have you ever had any type of cancer, including leukemia? YES NO

9. Have you ever had a bleeding condition or blood disease, including sickle cell disease? . YES NO

10. Have you ever had a bleeding problem, such as hemophilia or other clotting factor deficiencies, and received human-derived clotting factor concentrates? YES NO
11. Have you been diagnosed with West Nile Virus during your pregnancy?. YES NO
12. Have you ever had yellow jaundice, liver disease, viral hepatitis, or a positive test (including screening tests) for hepatitis? YES NO
13. Have you ever had Chagas' disease or Babesiosis?. YES NO
14. Have you or any of your blood relatives ever been diagnosed with Creutzfeldt-Jakob Disease (CJD)? YES NO
15. Have you ever received a dura mater (brain covering) graft? YES NO
16. Have you ever had a transplant or medical procedure that involved being exposed to live cells, tissues or organs from an animal?. YES NO
17. 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?. YES NO

In the past 3 years:

18. Have you had malaria? YES NO
19. Have you been outside the United States or Canada? YES NO

If yes, please list where, when, and for how long? _____

In the past 12 months:

20. Have you had a blood transfusion? YES NO
21. Have you had a transplant such as organ, tissue or bone marrow? YES NO
22. Have you had a tissue graft such as bone or skin?. YES NO
23. Have you had a tattoo? YES NO

If yes, answer question 24. **If no**, skip to question 25.

24. Were shared instruments, needles or inks used for the tattoo?. YES NO
25. Have you had an ear, skin, or body piercing using shared instruments or needles? YES NO
26. Have you had an accidental needle stick or have you come into contact with someone else's blood through an open wound, non-intact skin or mucous membrane (for example, into your eye, mouth, etc)? YES NO

27. Have you had or been treated for a sexually transmitted disease, including syphilis or gonorrhea?YES NO
28. Have you given money, drugs or other payment to anyone to have sex with you?.YES NO
29. Have you had sex with anyone who has taken money, drugs or other payment in exchange for sex in the **past 5 years**?YES NO
30. Have you had sexual contact or lived with a person who has active or chronic viral hepatitis or yellow jaundice?YES NO
31. Have you had sex, even once, with anyone who has used a needle to take drugs, steroids, or anything else not prescribed by a doctor in the **past 5 years**?YES NO
32. Have you had sex with a male who has had sex with another male, even once, in the **past 5 years**?YES NO
33. Have you had sex, even once, with anyone who has taken clotting factor concentrates for a bleeding problem such as hemophilia?YES NO
34. Have you had sex, even once, with anyone who has HIV / AIDS or has had a positive test for the AIDS virus?. YES NO
35. Have you been in juvenile detention, lockup, jail or prison for more than 72 continuous hours?YES NO
- In the past 5 years:**
36. Have you received money, drugs or other payment for sex?. YES NO
37. Have you used a needle, even once, to take drugs, steroids, or anything else not prescribed for you by a doctor?. YES NO
38. Do you have AIDS or have you ever tested positive for HIV (including screening tests)? YES NO
39. Have you ever tested positive for HTLV (including screening tests)?YES NO
40. 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?YES NO

**For questions 41 through 50, please refer to the chart below for a list of countries involved:
Reference Guide for Questions 41 & 44: Countries defined as Europe**

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

Reference Guide for Questions 48 - 50: African Countries

Cameroon	Chad	Equatorial Guinea	Niger
Central African Republic	Congo	Gabon	Nigeria

41. **Since 1980**, have you ever lived in or traveled to Europe? (refer to chart) YES NO
If yes, answer questions 42 through 44. **If no**, skip to question 45.

42. **From 1980 through 1996**, did you spend time that **adds up to 3 months or more** in the United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands)? YES NO

43. **Since 1980**, have you received a transfusion of blood, platelets, plasma, cryoprecipitate, or granulocytes while in the U.K.? YES NO

44. **Since 1980**, have you spent time that adds up to 5 years or more in Europe (refer to chart), including time spent in the U.K. between 1980 and 1996? YES 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? YES NO
If yes, answer questions 46 and 47. **If no**, skip to question 48.

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: U.K., Belgium, Netherlands or Germany? YES 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? YES NO

48. **Since 1977**, were you born in, have you lived in, or have you traveled to any African country listed in the chart? YES NO
If yes, answer question 49. **If no**, skip to question 50.

49. While in one of the African countries listed in the chart, did you receive a blood Transfusion or any other medical treatment with a product made from blood? YES NO

50. **Since 1977**, have you had sexual contact with anyone who was born in or lived in any African country listed in the chart? YES NO

Addendum: Severe Acute Respiratory Syndrome (SARS)

- 1. **In the past 28 days**, have you been ill with SARS or suspected SARS? YES NO

- 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? YES NO

- 3. **In the past 14 days**, have you traveled outside of the United States?.YES NO

- 4. **In the past 14 days**, has someone you live with traveled to, traveled through, or resided in areas affected by SARS? YES NO

- 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?. . . YES NO

Indiana Cord Blood Bank- Family Medical History Questionnaire

Please read questions carefully and answer to the best of your knowledge.

(circle)

1. Is this your first pregnancy? YES NO
If no, answer questions 2 through 6. **If yes**, skip to question 7.

2. How many other pregnancies have you had? YES NO

3. How many live born children resulted from the other pregnancies? YES NO

4. Have you had any children who died within the first 10 years of life? YES NO

If yes, what was the cause? _____

5. Have you ever had a miscarriage? YES NO

If yes, how many? _____

6. Have you ever had a stillborn child? YES NO

If yes, how many? _____

7. Have you ever had an abnormal result from a prenatal test (e.g. amniocentesis, blood test, ultrasound)? YES NO

If yes, what was the abnormal test result? _____

8. Are you and the baby's father related, except by marriage (e.g. first cousins)? YES NO

9. Did this pregnancy use either a donor egg or donor sperm? YES NO

10. Are you or the baby's father adopted? YES NO

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:

BM Baby's Mother

BF Baby's Father

BS Baby's Sibling (brother or sister)

BGP Baby's Grandparent (grandmother or grandfather)

BMS Baby's Mother's Sibling*

BFS Baby's Father's Sibling*

*Parents' siblings (BMS and BFS) refer to the baby's aunts and uncles by blood and do not include aunts and uncles who are in-laws of the parents.

(circle) 11. Cancer or Leukemia before age 20?YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 11, please specify all that apply in questions 12 through 21.</p> <p>12. Brain or other nervous system cancer.</p> <p>13. Bone or joint cancer.</p> <p>14. Kidney (including renal pelvic) cancer</p> <p>15. Skin cancer</p> <p>16. Thyroid cancer</p> <p>17. Hodgkin's lymphoma</p> <p>18. Non-Hodgkin's lymphoma</p> <p>19. Acute myelogenous / myeloid leukemia.</p> <p>20. Acute lymphocytic / lymphoblastic leukemia</p> <p>21. Other cancer / leukemia.</p> <p>Specify Type: _____</p>						

Answer questions 22 through 25.	BM	BF	BS	BGP	BMS	BFS
<p style="text-align: right;">(circle)</p> <p>22. Required chronic blood transfusions?YES NO</p> <p>23. Been told they have hemolytic anemia? YES NO</p> <p>24. Had their spleen removed to treat a blood disorder?YES NO</p> <p>25. Had their gallbladder removed before age 30?YES NO</p>						

(circle) 26. Red Blood Cell Diseases?YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 26, please specify all that apply in questions 27 through 34.</p> <p>27. Sickle Cell Disease.</p> <p>28. Thalassemia.</p> <p>29. Fanconi Anemia</p> <p>30. G6PD or other red cell enzyme deficiency.</p> <p>31. Spherocytosis</p> <p>32. Elliptocytosis</p> <p>33. Diamond-Blackfan Syndrome</p> <p>34. Other or unknown red blood cell disease</p>						

(circle) 35. White Blood Cell Diseases?.....YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 35, please specify all that apply in questions 36 through 38.</p> <p>36. Chronic Granulomatous Disease</p> <p>37. Wiskott-Aldrich Syndrome.</p> <p>38. Other or unknown white blood cell disease.</p>						

(circle) 39. Immune Deficiencies?YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 39, please specify all that apply in questions 40 through 45.</p> <p>40. SCID</p> <p>41. Hypoglobulinemia</p> <p>42. Nezeloff Syndrome.</p> <p>43. ADA or PNP Deficiency.</p> <p>44. DiGeorge's Syndrome</p> <p>45. Other or unknown immune deficiency</p>						

(circle) 46. Metabolic / Storage Diseases?.....YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 46, please specify all that apply in questions 47 through 55.</p> <p>47. Tay-Sachs Disease.</p> <p>48. Leukodystrophies, e.g. Globoid Leukodystrophy (Krabbe Disease), Metachromatic Leukodystrophy (MLD), Adrenoleukodystrophy (ALD).</p> <p>49. Ataxia-Telangiectasia</p> <p>50. Gaucher Disease</p> <p>51. Hurler Syndrome</p> <p>52. Hunter Syndrome.</p> <p>53. Porphyria</p> <p>54. Sanfilippo Syndrome</p> <p>55. Other or unknown metabolic / storage disease</p>						

(circle) 56. Platelet Diseases?YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 56, please specify all that apply in questions 57 through 60.</p> <p>57. Glanzmann's Disease.</p> <p>58. Hereditary Thrombocytopenia</p> <p>59. Platelet Storage Pool Disease</p> <p>60. Other or unknown platelet disease</p>						

(circle) 61. Immune System Disorders?YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 61, please specify all that apply in questions 62 through 65.</p> <p>62. HIV / AIDS</p> <p>63. Rheumatoid Arthritis.</p> <p>64. Lupus</p> <p>65. Other or unknown immune system disorder</p>						

(circle) 66. Neurological Disorders?YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 66, please specify all that apply in questions 67 through 68.</p> <p>67. Creutzfeldt-Jakob Disease</p> <p>68. Other or unknown neurological disorder</p>						

(circle) 69. Other Diseases Affecting Family?YES NO	BM	BF	BS	BGP	BMS	BFS
<p>If yes to question 69, list the type of disease and select affected family member(s).</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>						

70. In answering these questions, have you answered for both your family and the baby's father's family? YES NO

Please specify other or unknown diseases or disorders for affected family members identified in the previous questions:

Question 34: Red Blood Cell Disease _____

Question 38: White Blood Cell Disease _____

Question 45: Immune Deficiency _____

Question 55: Metabolic/Storage Disease _____

Question 60: Platelet Disease _____

Question 65: Immune System Disorder _____

Question 68: Neurological Disorder _____

Indiana Cord Blood Bank- Confidential Maternal Demographic Information

Baby's Mother's Information:

Last Name(s) Maiden Name

First Name Middle Name Date of Birth / / Age
M M D D Y Y Y Y

Due Date / / Delivering Hospital
M M D D Y Y Y Y

Is this a multiple birth pregnancy?..... (circle) YES NO

E-mail address

Home Phone - - Alternate Phone - -

Baby's Mother's Current mailing Address:

Street

City State Zip/Postal Code -

Baby's Father's Information:

Last Name(s) First Name

Address (if different from baby's mother's address)

City State Zip/Postal Code -

Home Phone - - Alternate Phone - - Date of Birth / /

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
- Central/South American Indian
- North American Indian
- Caribbean Indian

Black or African American

- African
- African American
- Black Caribbean
- Black Central/South American

Asian

- Chinese
- Filipino (Philipino)
- Japanese
- Korean
- South Asian
- Vietnamese
- Other South East Asian

Native Hawaiian or Other Pacific Islander

- Guamanian
- Hawaiian
- Samoan
- Other Pacific Islander

White

- Central/South American White
- Eastern European
- Mediterranean
- Middle Eastern
- North American

- Northern European
- North Coast of Africa
- Western European
- White Caribbean

Obstetrician / Midwife Information:

Last Name

First Name

M.D. R.N., C.N.M.

Clinic Name

Phone Number - -

Address

City

State

Zip/Postal Code -

Indiana Cord Blood Bank- Delivery Information

(To be completed by the caregiver)

Cord Blood unit (CBU) Collection Guidelines

This form contains information the cord blood bank uses to evaluate the cord blood donation in order to minimize risk to the patient. If you have any questions, please contact the cord blood bank.

Physical assessment of the baby's mother must be documented. FDA recommends screening for signs that may indicate high-risk behavior and/or infection with a relevant communicable disease. The following are examples of physical evidence to look for:

- Sexually transmitted diseases such as genital ulcerative disease, herpes simplex, syphilis, chancroid
- Active illicit drug use such as needle tracks, examination of tattoos which may be covering needle tracks, etc.
- Recent tattooing, ear or body piercing
- Lymphadenopathy
- Oral Thrush
- Blue spots or purple spots consistent with Kaposi's sarcoma
- Unexplained jaundice, hepatomegaly or icterus
- Physical evidence of sepsis, such as unexplained generalized rash
- Large scab, rash, or necrotic lesion consistent with immunizations
- Generalized vesicular rash

Please make note of any symptoms of acute sepsis or infection which may be present at the time of delivery in the Baby's Mother's Health Comments section on the form.

Cord blood should not be collected when there is presence of placental tears, pus, foul odor, infection of placenta or amniotic fluid, placental abruption or trauma (i.e. partial avulsion of umbilical cord from the placental plate).

Physical assessment of the baby should include screening for fetal malformations which include metabolic disorders, chromosomal abnormalities, or structural anomalies, including, but not limited to evidence of:

- Absent digits on hands or feet
- Absent radii
- Extra digits on hands or feet
- Horseshoe kidney
- Microcephaly
- Dwarfism
- Albinism

Please make note if the baby had any signs or symptoms of possible sepsis or congenital infection in the Baby's Health Comments section on the form.

Baby's Mother's Information:

Last Name(s)

Maiden Name

First Name

Middle Name

Date of Birth

 / /

M M D D Y Y Y Y

Delivering Hospital

Delivering Obstetrician/Midwife's Last Name

(circle)

Evidence of significant genital HPV infection, active genital herpes or suspected prodrome?

YES NO

Antibiotics received during labor?

YES NO

Specify Type:

Reason (circle):

Chorioamnionitis

Group Beta Strep

Fever

Other

If "Other" please specify:

Mother's highest temperature prior to delivery: ° C F

Baby's Mother's Physical Assessment Date:

 / /

M M D D Y Y Y Y

Were any abnormal findings detected during the physical assessment to indicate risk of communicable disease or high risk behavior?

YES NO

Please explain: _____

Any additional comments regarding baby's mother's health: _____

Labor and Delivery Information

Delivery Date
 / /
M M D D Y Y Y Y

Time
 :
H H M M

Type of Delivery (circle): Vaginal C-Section

Reason for C-Section (circle): Elective Fetal Distress Maternal Reason Other

If "Other" please explain: _____

Delivery Events and Complications: (circle)

Rupture of membranes before delivery?..... YES NO

If yes, length of time (hours): _____

Presence or suspicion of chorioamnionitis?..... YES NO

Fetal distress?..... YES NO

Blood transfusion during labor and delivery?..... YES NO

Excessive maternal bleeding?..... YES NO

Other complications during pregnancy or birth: _____

Baby's Information:

Baby's Sex: Male Female

Baby's Weight: _____ . _____ grams pounds

Gestational Age (in weeks): _____

Did the umbilical cord have 3 vessels? YES NO

Baby's Health

Baby's Physical Assessment Date

MM/DD/YYYY

(circle)

Evidence of congenital anomalies (metabolic disorders, chromosomal or structural abnormalities)? YES NO

Evidence of congenital infection (petechial rash, hepatosplenomegaly, thrombocytopenia)? YES NO

Evidence of infant sepsis? YES NO

Baby's temperature >38.5°C? YES NO

Additional comments regarding baby's health: _____

Cord Blood Unit (CBU) Collection Information

CBU Collection Date: MM/DD/YYYY

Time: HH:MM

Type of Collection: In Utero Ex Utero

CBU Collector Last Name(s)

CBU Collector First Name

Type of CBU Collector (please check one) MD Nurse Bank Staff Other

If "Other" please specify: _____

CBU Collector Signature:

Signature _____

Today's Date MM/DD/YYYY

Indiana Cord Blood Bank- Follow Up Information

NOTE: you may send in this form in the stamped envelope provided or call the study coordinator at 317-917-3462 to satisfy the follow-up requirement.

This form contains information the cord blood bank uses to evaluate the cord blood donation in order to minimize risk to a potential patient. If you have any questions, please contact the cord blood bank.

Mother's Information:

Last Name(s)										Maiden Name									
<input type="text"/>										<input type="text"/>									
First Name					Middle Name					Date of Birth									
<input type="text"/>					<input type="text"/>					<input type="text"/>		/		<input type="text"/>		/		<input type="text"/>	
										M M		D D		Y Y Y Y					
Delivering Hospital										Delivering Obstetrician/Midwife's Last Name									
<input type="text"/>										<input type="text"/>									

Baby's Information:

Last Name(s)										First Name									
<input type="text"/>										<input type="text"/>									
Middle Name					Date of Birth														
<input type="text"/>					<input type="text"/>		/		<input type="text"/>		/		<input type="text"/>						
					M M		D D		Y Y Y Y										

Please indicate yes or no to the following:

Does your child show signs or symptoms of the following?

	YES	NO
Absent digits on hands or feet.	_____	_____
Absent radii.	_____	_____
Extra digits on hands or feet.	_____	_____
Horseshoe kidney.	_____	_____
Microcephaly.	_____	_____
Hemihypertrophy.	_____	_____
>6 café au lait spots.	_____	_____
Dwarfism.	_____	_____
Albinism.	_____	_____

Thank you for your participation!