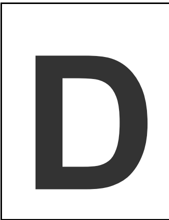
Victoria Angel Registry of Hope



Cells For Life's Non-Profit Donor Program
Markham Stouffville Health Centre, 377 Church Street, #201, Markham, Ontario, L6B 1A1
Toronto General Hospital, 585 University Ave., #BC8131, Toronto, Ontario M5G 2N2
Calgary - Garrison Green, 5 Richard Way S.W., Suite 300, Calgary, Alberta T3E 7M8
Tel: (905) 472-0060 or 1-877-235-1997, Fax: (905) 472-2185, email: info@cellsforlife.com

CONFIDENTIAL HEALTH & RISK ASSESSMENT QUESTIONNAIRE

This confidential medical health / risk assessment questionnaire must be completed by both parents and the information will be used to assess your suitability as a candidate for the cord blood storage program. If you are unsure of any particular disease or condition that you may have or have been exposed to, please consult your family doctor. You may review our Privacy Policy online at www.cellsforlife.com or phone our office to request a copy. You will be required to update this information at the time of birth and to return the updated form with your cord blood sample to Cells for Life.

PLEASE PRINT	MOTHER	FATHER/PARTNER
First Name		
Last Name		
Occupation		
Ethnic Ancestry		

	QUESTIONS A & B – If Birth Mother is positive, the sample will NOT be stored.	Mother	Partner
A	Have you ever tested POSITIVE for HIV / HTLV I/II?	Yes ☐ No ☐	Yes ☐ No ☐
B	Are you a Hepatitis B or C carrier?	Yes ☐ No ☐	Yes ☐ No ☐

	PREGNANCY	Mother	
1	Have you experienced any complications during this pregnancy or previous pregnancies?	Yes ☐ No ☐	
2	Have you received any blood products during pregnancy (includes IVIG or Rhogam)?	Yes ☐ No ☐	
3	Was this pregnancy conceived as a result of in-vitro fertilization, ovum donation, donor sperm or surrogacy? (Circle as appropriate.)	Yes ☐ No ☐	
4	I am under the care of a licensed physician/midwife.	Yes ☐ No ☐	
5	Have you had the opportunity to review any Cells for Life educational materials?	Yes ☐ No ☐	

	GENERAL HEALTH	Mother	Partner
6	Have you ever been diagnosed with jaundice (other than newborn), liver disease or tested +ve for Hepatitis?	Yes ☐ No ☐	Yes ☐ No ☐
7	Have you been immunized against Hepatitis B?	Yes ☐ No ☐	Yes ☐ No ☐
8	Have you ever received a blood transfusion?	Yes ☐ No ☐	Yes ☐ No ☐
9	Have you ever been refused as a blood donor or told not to donate? When? ____________________ Reason for refusal________________________________	Yes ☐ No ☐	Yes ☐ No ☐
10	Have you had a tissue (e.g. gum or bone graft), organ, or bone marrow transplant?	Yes ☐ No ☐	Yes ☐ No ☐
11	Have you been told that you or a close relative has been diagnosed with Creutzfeld-Jakob Disease (Mad Cow Disease)?	Yes ☐ No ☐	Yes ☐ No ☐
12	Have you had Babesiosis or Chagas' Disease?	Yes ☐ No ☐	Yes ☐ No ☐
13	Do you suffer from Hemophilia or a clotting disorder or any other hereditary blood disorders (e.g. sickle cell anemia, thalassemia)?	Yes ☐ No ☐	Yes ☐ No ☐

14	Are you currently suffering from a bacterial, viral or fungal infection?	Yes ☐ No ☐	Yes ☐ No ☐
15	Are you a diabetic who requires insulin? Type ______________________________	Yes ☐ No ☐	Yes ☐ No ☐
16	Have you been in contact with someone who has Tuberculosis?	Yes ☐ No ☐	Yes ☐ No ☐
17	Do you or any other member of your family suffer from a genetic or hereditary disease?	Yes ☐ No ☐	Yes ☐ No ☐
18	Do you have a family history of MS, Alzheimer's, Parkinsons or ALS (Lou Gehrig's disease)?	Yes ☐ No ☐	Yes ☐ No ☐

	IN THE PAST FEW WEEKS, HAVE YOU:	Mother	Partner
19	Been in a facility that has been placed under quarantine for any infectious disease?	Yes ☐ No ☐	Yes ☐ No ☐
20	Suffered from undiagnosed or diagnosed infections or suffered from fever or cough?	Yes ☐ No ☐	Yes ☐ No ☐
21	Been on any medication (excluding prenatal vitamins)? Please list any medications: ____	Yes ☐ No ☐	Yes ☐ No ☐
22	Had contact with someone who had a smallpox vaccination in the past few weeks?	Yes ☐ No ☐	Yes ☐ No ☐

	IN THE PAST 12 MONTHS, HAVE YOU:	Mother	Partner
23	Received any body piercing, tattoos, permanent make-up or acupuncture?	Yes ☐ No ☐	Yes ☐ No ☐
24	Used a needle not prescribed by a physician or had sex with someone who has?	Yes ☐ No ☐	Yes ☐ No ☐
25	Had close personal or sexual contact or lived with anyone diagnosed with HIV/HTLV I/II, Hepatitis B or Hepatitis C or any other sexually transmitted disease or paid for sex with a prostitute?	Yes ☐ No ☐	Yes ☐ No ☐
26	Been diagnosed with West Nile Virus?	Yes ☐ No ☐	Yes ☐ No ☐
27	Been treated for any sexually transmissible disease such as Syphilis, Gonorrhea, Herpes or Chlamydia?	Yes ☐ No ☐	Yes ☐ No ☐
28	Been to a malaria endemic country? Example: Dominican Republic, Africa	Yes ☐ No ☐	Yes ☐ No ☐
29	Received any vaccinations/immunizations?	Yes ☐ No ☐	Yes ☐ No ☐
30	Received money, drugs or other payment for sex?	Yes ☐ No ☐	Yes ☐ No ☐
31	Had an accidental needle stick or been in contact with someone else's blood?	Yes ☐ No ☐	Yes ☐ No ☐
32	Been bitten by an animal and treated with the assumption that the animal was rabid (or exposed to someone who has)?	Yes ☐ No ☐	Yes ☐ No ☐

	IN THE PAST 5 YEARS, HAVE YOU BEEN:	Mother	Partner
33	In a correctional facility for more than 72 hours?	Yes ☐ No ☐	Yes ☐ No ☐
34	Been outside of Canada or the United States? Where? ______________________________________	Yes ☐ No ☐	Yes ☐ No ☐

	SINCE 1980 TO THE PRESENT, HAVE YOU:	Mother	Partner
35	Spent time that adds up to 3 months in the United Kingdom or 5 years or more in Europe? Country: ____	Yes ☐ No ☐	Yes ☐ No ☐
36	Received a blood transfusion in the United Kingdom or France?	Yes ☐ No ☐	Yes ☐ No ☐

	HAVE YOU EVER:	Mother	Partner
37	Lived or been in Africa or had sexual contact with someone who did?	Yes ☐ No ☐	Yes ☐ No ☐
38	Had any type of cancer, including Leukemia?	Yes ☐ No ☐	Yes ☐ No ☐

39	Received a dura mater (or brain covering) graft?	Yes ☐ No ☐	Yes ☐ No ☐
40	Had Malaria?	Yes ☐ No ☐	Yes ☐ No ☐
41	Had sexual contact with a male who has had sex with another male?	Yes ☐ No ☐	Yes ☐ No ☐
42	Had sex with someone who has injected non-medicinal drugs (including steroids)?	Yes ☐ No ☐	Yes ☐ No ☐
43	Received Human Pituitary-derived growth hormones or clotting factor concentrates?	Yes ☐ No ☐	Yes ☐ No ☐
44	Or your partner ever had a transplant or other medical procedure that involved being exposed to live cells, tissues or organs from an animal?	Yes ☐ No ☐	Yes ☐ No ☐

Please indicate and clarify any 'YES' answers.

I certify that I have answered the above questions truthfully and to the best of my knowledge. I understand that if after banking my Child's Umbilical Cord Blood, I decide for any reason that the Cord Blood should not be used, I will contact Cells For Life at the earliest possible opportunity.

________________________ **Date:** / / **Mother's Signature**	________________________ **Date:** / / **Father / Partner's Signature**
Telephone: ( )	

For office use only. Comments:

________________________ Date: / /
Cells for Life's Physician/Nurse's Signature

Birthing Mother to complete at Birth:
Yes No

Are there any changes to the above information?
_____ _____
Are you currently healthy? *Answer **Yes** if you are healthy*
_____ _____
Are you taking any antibiotics other than for Strep B?
_____ _____
4. **Have you been in contact with an infectious disease during the past 2 weeks?**
_____ _____
Have you received any blood products during delivery? (i.e. transfusion)
_____ _____
6. **Do you currently have a cold sore or mouth ulceration?**
_____ _____
Write details on reverse. >>>>> PLEASE INITIAL:
____