



**Thank you for considering cord blood donation.**

**Please ensure that you have reviewed the acceptance criteria indicated below before submitting a registration packet.**

**Many criteria are examined to determine acceptance to the program.**

**Both Mother and Father must complete all forms then fax to**

**(905) 472 2185**

- Birth mothers must never have tested positive for HIV or be a Hepatitis B or C carrier
- Birth mothers must be > 18 years of age
- Must register prior to 34 weeks gestation
- Singleton birth – no twins/ triplets can be accepted
- Health and risk restrictions are set by the AABB/ World public banking standards:
  - Review of health, obstetrical, and genetic history
  - Review of previous travel destinations
  - No tattoo, acupuncture or piercing in last 12 months
  - No treatment for sexually transmissible disease in last 12 months
- Birthing centre location – parents giving birth in selected Southern Ontario Cities only\*
- Health professional cooperation
- Current number of participants in the VAR program
- Willingness to meet the program guidelines

- \* Hospitals serviced by our bedside pickup service include the following hospitals: Ajax Pickering, Brantford General, Cambridge Memorial, Credit Valley, Georgetown, Grand River, Guelph General, Humber River (Church & Finch), Joseph Brant Burlington, Markham Stouffville, McMaster, Milton District, Mt. Sinai Toronto, North York General, Oakville Trafalgar, Scarborough Centenary/ General/ Grace, Southlake, St. Joseph's Hamilton, St. Joseph's Toronto, St. Michael's Toronto, Toronto East General, Trillium Health Centre (Mississauga), William Osler (Brampton Civic & Etobicoke), Women's College, York Central.

\*\*All other locations: Parents are asked to have a friend or family member deliver the sample to the laboratory at Toronto General Hospital or pay the cost of shipping to help reduce the financial strain on the non-profit public bank. As funding is increased, this will not be required.

**Mailing address: Forms can be completed and mailed to:  
Victoria Angel Registry of Hope, 201 – 377 Church Street, Markham, ON L6B 1A1**

**Thank you**



**REGISTRATION FORM - Please complete and fax to (905) 472 2185**

I/ We would like to donate our child's umbilical cord blood to the Victoria Angel Registry of Hope for others to use:

PLEASE PRINT CLEARLY (Black ink)	MOTHER	FATHER/ PARTNER
FIRST NAME		
LAST NAME		
DATE OF BIRTH (Month/ Day/ Year)		
WORK PHONE		
EMAIL		

HOME ADDRESS			
CITY, PROVINCE/ STATE			
POSTAL CODE/ ZIP/ COUNTRY			
HOME PHONE & EMAIL			
CELL PHONE			
EXPECTED DUE DATE	Month:	Day:	Year: TWINS: <small>Not accepted for public banking</small>
DELIVERY HOSPITAL NAME	CITY		
PRENATAL Dr/ MIDWIFE			

How did you hear about the Victoria Angel Registry of Hope:

SIGNATURE MOTHER	SIGNATURE FATHER/ PARTNER
Date:	Date:

# 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](mailto: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](http://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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
B	Are you a Hepatitis B or C carrier?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GENERAL HEALTH		Mother	Partner
6	Have you ever been diagnosed with jaundice (other than newborn), liver disease or tested +ve for Hepatitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7	Have you been immunized against Hepatitis B?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Have you ever received a blood transfusion?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Have you ever been refused as a blood donor or told not to donate? When? _____ Reason for refusal _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Have you had a tissue (e.g. gum or bone graft), organ, or bone marrow transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11	Have you been told that you or a close relative has been diagnosed with Creutzfeld-Jakob Disease (Mad Cow Disease)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12	Have you had Babesiosis or Chagas' Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13	Do you suffer from Hemophilia or a clotting disorder or any other hereditary blood disorders (e.g. sickle cell anemia, thalassemia)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14	Are you currently suffering from a bacterial, viral or fungal infection?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
15	Are you a diabetic who requires insulin? Type _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
16	Have you been in contact with someone who has Tuberculosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
17	Do you or any other member of your family suffer from a genetic or hereditary disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
18	Do you have a family history of MS, Alzheimer's, Parkinsons or ALS (Lou Gehrig's disease)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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HEALTH & RISK ASSESSMENT QUESTIONNAIRE

	<b>IN THE PAST 12 MONTHS, HAVE YOU:</b>	<b>Mother</b>	<b>Partner</b>
23	Received any body piercing, tattoos, permanent make-up or acupuncture?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
24	Used a needle not prescribed by a physician or had sex with someone who has?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
26	Been diagnosed with West Nile Virus?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
27	Been treated for any sexually transmissible disease such as Syphilis, Gonorrhoea, Herpes or Chlamydia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
28	Been to a malaria endemic country? Example: Dominican Republic, Africa	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



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: / / <b>Mother's Signature</b>	_____ Date: / / <b>Father / Partner's Signature</b>
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Telephone: ( )

For office use only. Comments:

\_\_\_\_\_ Date: / /  
 Cells for Life's Physician/Nurse's Signature

<b>Birthing Mother to complete at Birth:</b>	<b>Yes</b>	<b>No</b>
1. Are there any changes to the above information?	_____	_____
2. Are you currently healthy? <i>Answer Yes if you are healthy</i>	_____	_____
3. 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?	_____	_____
5. Have you received any blood products during delivery? (i.e. transfusion)	_____	_____
6. Do you currently have a cold sore or mouth ulceration?	_____	_____
<b>Write details on reverse. &gt;&gt;&gt;&gt; PLEASE INITIAL: _____</b>		