biosurance

Family stem cell bank from umbilical cord blood

Registration documents and informed consent

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Registration form

IDENTIFICATION

I/we wish to register. Please indicate only one of the following

☐ **Cord blood**

☐ **Cord blood and umbilical cord (PERISTEM™)**

PLEASE COMPLETE THIS SECTION IN CAPITALS

Mother as per health card	First name		Last name	
Date of birth	day-month-year		**Email**	
Health insurance	#		Expiry date	
Occupation			Employer	
Telephone number	Home	Office		Cell.
Complete address	Number, street		City	
	Province	Postal Code		Country

Expected delivery date		**Current pregnancy :** ☐ single pregnancy (one baby)	☐ twin pregnancy
Are you carrying a baby for someone else? If so, the birth mother and biological mother each need to complete a confidential medical questionnaire.			☐ yes ☐ no
Delivery hospital		**Birth at home**	☐ yes ☐ no
Place	City	Province	**Telephone**

Obstetrician/Midwife	Name	
Place	Clinic	City

Father / Partner as per health card	First name		Last name	
Date of birth	day-month-year		**Email**	
Health insurance	#		Expiry date	
Occupation			Employer	
Telephone number	Home	Office		Cell.
Complete address ☐ same as mother or:	Number, street		City	
	Province	Postal Code		Country

Other contact (optional)	Name		**Relation**	
Telephone number	Home	Office		Cell.
Complete address	Number, street		City	
	Province	Postal Code		Country

Comments: _____

How did you hear about us? _____

Referred by: _____

Consent form

This consent is applied for the collection and the preservation of : *(indicate chosen service)*

☐ Cord blood

☐ Cord blood and umbilical cord (PERISTEM™)

I, _____ (mother)

and _____ (father / partner), (hereinafter, "We")

authorize the collection of a section of the umbilical cord and/or umbilical cord blood, (hereinafter "Umbilical Sample") of our child (hereinafter "the Child") to be sent to **ovo biosurance** (hereinafter "the Bank") for processing, testing, cryopreservation (freezing) and storage of stem cells from the perivascular umbilical tissue and/or of the umbilical cord blood (hereinafter "Stem Cells").

I (the mother) understand that it is my responsibility to answer accurately all questions in the medical questionnaire. We understand that the medical questionnaire will be reviewed to determine the Childs Umbilical Sample's eligibility for storage and that a positive or incomplete response may restrict its eligibility for storage and/or future use.

We understand that this consent permits the collection, processing and testing of the Child's Umbilical Sample and, the cryopreservation and storage of the Child's Stem Cells. We understand that the umbilical cord and the umbilical cord blood are usually discarded after the Child`s delivery. We wish to do the collection and processing of the Child's Umbilical Sample in order to preserve any Stem Cells contained therein so they may be available as a possible future treatment for disease(s) in the Child, and/or, if eligible, other persons.

We have been fully informed about the Umbilical Sample collection process. We consent to and will request that our health care provider, following the birth of the Child, collect the Umbilical Sample using the collection kit supplied by the Bank. We understand that while an attempt will be done to collect the Umbilical Sample at the time of the delivery, there is no guarantee or assurance of the success of the collection procedure. We understand that medical and/or obstetric circumstances and/or technical difficulties linked to the collection could constitute an obstacle to the collection of adequate Umbilical Sample. We understand that the collection kit cannot be returned or reimbursed in any circumstances.

We understand that We are responsible for:

- sending the Child's Umbilical Sample along with the birth mother's blood samples and the required documentation, to the Bank, as per the Bank`s instructions and that the Bank is not responsible for the Child's Umbilical Sample before its arrival at its laboratories.
- ensuring that the Child's Umbilical Sample is delivered at the Bank as soon as possible after collection, and never more than twenty four (24) hours after the birth of the Child. We understand that the efficacy and viability of the Stem Cells may be reduced if the Umbilical Sample arrives at the Bank more than thirty six (36) hours after the birth of the Child.
- ensuring that the collection kit, both before and after the collection of the Child's Umbilical Sample, is maintained near room temperature (recommended temperature between 19 and 25˚C). We understand that the efficacy and viability of the Stem Cells may be reduced if the Child's Umbilical Sample is not maintained at the appropriate temperature prior to its delivery at the Bank.

Mother's initials ☐ Father's/Partner's initials ☐

We understand that the quantity and quality of the Stem Cells extracted from the Child's Umbilical Sample can only be assessed after the Child's Umbilical Sample has been processed. We understand that there is no guarantee that the Stem Cells obtained from the Child's Umbilical Sample, if there are any, will be suitable for storage and/or for future transplantation or for another use. We understand that it is not possible to know if the Child's Umbilical Sample fulfills the Bank's storage requirements or if there will be any limitations on its eligibility for use before knowing the results of all the admission tests.

We understand specifically that:

a. contamination of the Child's Umbilical Sample by micro-organisms (e.g. bacteria, fungus, etc.) occurring during the birth, could make the Child's Stem Cells unusable for transplantation or for other medical use;

b. the Child's Umbilical Sample, could contain insufficient numbers of viable Stem Cells for transplantation or for another medical use;

c. there is no guarantee that the Child's Stem Cells will survive the processing, the cryopreservation and/or the thawing process;

d. the success of a transplantation or another medical use of the Child's preserved Stem Cells cannot be guaranteed;

e. if the Child's birth mother suffers from or has suffered from a transmissible disease, it may not be possible to store and/or use the Child's Stem Cells for future transplantation or for another medical use;

f. in accordance with the regulations in place, the Bank is required to conserve an aliquot of the Umbilical Sample in the eventuality that further testing for transmissible or genetic disease needs to be performed;

g. the Bank reserves the right to reject any Umbilical Sample in the absence of the provision of the birth mothers blood in the required time period or if the Umbilical Sample is received by the Bank more than 36 hours after the delivery of the Child or if the Umbilical Sample does not meet the current Health Canada regulations;

h. the decision on who can or cannot use the Child's Stem Cells will be dependent on the birth/genetic mothers medical history and blood test results.

We understand that certain cord blood components, such as red blood cells and plasma remaining in the Child's Umbilical Sample after processing will not be stored in the bank with the Child's Stem Cells. We consent that the Bank will treat these components according to the regulations in force and may use them for quality control testing or validation of procedures.

We understand that the Bank, following the regulations of Health Canada, may be required to perform supplementary testing on the Child's Umbilical Sample and/or birth mothers blood, limiting the Bank's capacity to continue storage of the Child's Stem Cells.

We understand that for certain procedures involved in stem cell processing and storage, the Bank has to use the services of other medical suppliers to guarantee a complete service for storage of the Child`s Stem Cells.

SCREENING OF THE BIRTH MOTHER

We understand that the Child's birth mother is required to give blood samples to undergo testing for transmissible diseases, either during labour, or within seven days of the delivery date. The collection of blood samples should be done using the tubes included in the collection kit and should be sent to the Bank along with the Child's Umbilical Sample. We understand that an aliquot of this maternal blood sample is conserved by the Bank, if the volume permits, in the event that further testing by Health Canada is required at a later date. We also understand that if the Child's birth mother fails to give blood samples, it will not be possible to store or use the Child's Stem Cells. If the birth mothers screening tests are positive for HIV, hepatitis B, hepatitis C, syphilis or certain other infections, the Child's Stem Cells may not be suitable for storage and/or the eligibility of the Stem Cells for transplantation maybe limited. The Bank will inform us or my doctor of any positive or abnormal results. In certain cases, the Bank is obliged to inform the Quebec Public Health Laboratory the results of a positive test.

Mother's initials ☐ Father's/Partner's initials ☐

CONSIDERATION ABOUT THE CORD BLOOD VOLUME COLLECTED

Presently, the Bank's recommended minimum volume of umbilical cord blood for processing and storage (excluding the quantity required to perform the regulatory testing and the volume of the anticoagulant already present in the collection bag) is 30 ml. However, even if the volume of cord blood is below the recommended volume, the cord blood sample may still be valuable, in certain cases, for young children. Furthermore, advances in ex vivo expansion, gene therapy and cell research may enable the future use of stem cells derived from smaller volumes of umbilical cord blood.

We understand this and wish to proceed with the processing and storage of our cord blood sample regardless of the volume and agree to pay the processing fee and regular storage fees unless We have indicated to the contrary below.

☐ We wish to discard the cord blood sample if the volume is less than 30ml and for it not to be processed or stored. We understand that if We request this option, a sample with a volume less than 30ml will be permanently destroyed which is not reversible. In this situation, We will only pay the registration and collection kit fees and any applicable transportation charges. We understand that this option will only be considered as selected if We have signed below, otherwise our sample will be processed and stored and We will be liable to all regular fees. We understand that the preservation of the umbilical cord sample (PERISTEM), if chosen, is not implicated by this decision and will be processed independently.

If We have chosen not to process our cord blood sample when the volume is less than 30ml, and the actual volume of our sample is less than 30ml, We consent for our sample to be:

☐ Used for an approved research project or for the improvement/validation of laboratory techniques

☐ Disposed of in accordance with the standard protocol of the Bank.

Only to be signed if tick boxes above are filled.

Signature of mother	Signature of father/partner

COSTS

We understand that We are responsible for the costs of the birth mother's blood collection and testing, and also the processing, cryopreservation and storage of the Child`s Stem Cells. The payment plan option for the first year will be made when the cord blood collection kit is issued. In the eventuality where it is not possible to process the Child's Stem Cells, the Bank agrees to reimburse the costs paid proportionally to the work that has already been performed.

Standard payment plan

An initial fee of $400 is due and payable to the Bank after the completed medical questionnaire has been reviewed i.e. after the Bank receives a signed consent and the signed medical questionnaire. This initial fee of $400 is non refundable in any circumstances**.** The costs corresponding to the processing of the Child`s Umbilical Sample and the birth mother`s blood testing are payable by different payment schemes in one, two or three instalments. In each case, the payment of the first instalment includes the initial costs of $400.

Financing program

The first payment for the cord blood financing program will be made when the cord blood collection kit is issued and once the consent form and the medical questionnaire have been filled out and signed. A monthly payment will be made in the amount of 96.00$/month for a period of 12 months, not including taxes, transportation fees and HLA typing fees if applicable. These additional costs will be applied upon the first installment payment. In the event that the child's umbilical cord blood cannot be treated, a non refundable fee of 400$ will be applied. The initial payment schedule will continue to be effective until the initial 400$ has been collected. This does not include the transportation fees.

Storage fees for subsequent years

The costs for the annual storage of the Child`s Stem Cells are subject to change. The annual storage cost is due and payable at the beginning of each subsequent storage period. We also understand that the annual storage costs are not reimbursable and that no

Mother's initials ☐ Father's/Partner's initials ☐

proportional adjustments will be made for partial years of storage. The maximum duration for storage of the Child's Stem Cells will be governed by the laws in force in the province of Quebec and by the regulations of Health Canada.

We understand that, according to the chosen payment plan, an invoice covering the storage costs of the cryopreserved Child`s Stem Cells for the subsequent year will be sent to us thirty (30) days before the anniversary of the cryopreservation date, by regular mail at the last address We provided to the Bank. We understand and accept that the complete payment of this invoice is due within the thirty (30) days following the reception of the invoice. In case of non-payment, a second invoice will be sent 30 days later. Finally, in case of non-response, a registered letter will be sent to the same address, 30 days after the sending of the second invoice. If this registered letter is returned to sender or if the payment has not been settled ninety (90) days after the registered letter was mailed, We understand that this agreement will be considered as expired.

CONTACT DETAILS

We understand and agree to provide the Bank with our current address and a valid telephone number for as long as the Bank is storing the Child's Stem Cells, and We agree to update this information as appropriate. We understand and agree that it is our responsibility to inform the Bank of any changes in our names, address or telephone numbers. The Bank reserves the right to communicate with the birth mother at any time.

DISTRIBUTION, TRANSFER, DONATION AND/OR DESTRUCTION OF THE STEM CELLS

We understand and agree that:

- in order for the Bank to distribute, transfer, donate or destroy the Child's Stem Cells all the signatories of the present consent have to provide written consent for this distribution, transfer, donation or destruction.
- when the Child reaches the legal capacity, the authorization and the instructions for the distribution, transfer, donation or destruction of the Child's Stem Cells will be given to the Child itself or, if the Child is deceased, to the designated decision maker.
- the Bank, at its discretion, may refuse to distribute, transfer, donate or destroy the Stem Cells in the case of a misunderstanding between the Child's parents or if the Bank has legitimate concern on the validity of the consent, unless they receive an order from a court of Quebec directing and specifically authorizing their distribution, transfer, donation or destruction. In the event the Bank requires an order from the Court of Quebec for any of these reasons, the cost of obtaining this order will be borne solely by the parties that demand the distribution, transfer, donation or destruction of the Child's Stem Cells and not the Bank.
- in the case that a transplantation and/or another use of the Child's Stem Cells is medically prescribed, the frozen stored Child's Stem Cells will be transferred by the Bank to the designated medical facility only after the Bank receives a copy of the "Consent to send a frozen cord blood sample to a health care facility: FO-BSC-008" duly signed by all signatories of the present consent or by a person entitled with parental authority or by the Child's legal guardian and after any outstanding processing or storage costs have been paid in full. In the case of the Child's Stem Cells being used for transplantation or another medical usage, the Bank is responsible for the medical and administrative preparation of the Child's Stem Cell shipment to the designated medical facility and any storage fees already paid will be refunded proportionally for the storage period.
- in order to transfer the Stem Cells to another storage facility, the Bank must receive a copy of the "Consent to transfer cord blood sample stored at OVO Biosurance to another cord blood bank: FO-BSC-012" duly signed by all signatories of the present consent or by a person entitled with parental authority or by the Child's legal guardian. This consent would have to be signed at least a month before the intended transfer date. If We decide to transfer the Child's Stem Cells to another storage facility, We are responsible for all the arrangements regarding the transfer and that the only responsibility of the Bank is to prepare the Stem Cells for transfer. We accept any financial responsibility resulting from the transfer of the Child's Stem Cells along with the risks associated with the transfer of the Child's Stem Cells and that all the outstanding costs due to the Bank need to be paid before any transfer of the Child's Stem Cells.
- if the Bank ceases operations We will have the opportunity to transfer the Child's Stem Cells to another storage facility.
- the Bank reserves the right to relocate its business place and/or its operations even though the Bank does not currently plan relocation.

Mother's initials ☐ Father's/Partner's initials ☐

- the future use of the Child's Stem Cells by a person other than the Child may require further screening tests and/or additional blood tests from the birth mother of the Child and/or from the Child, and will be subject to the legislation in force at the moment of proposed usage.
- to have the Child's Stem Cells immediately eligible (from the moment of storage) for consideration for future use by a person other than the Child will require, before the cryopreservation of the Stem Cells, additional testing for HLA typing. We understand that an additional charge will be applied for HLA typing. The supplementary test would be performed on a small volume of the cord blood sample before its storage. We understand that it is likely that the Stem Cells would be not compatible, and therefore not usable, for a person who is not a blood relation of the Child. The supplementary charge for the HLA typing will non refundable in any circumstance.

☐ We wish to proceed with the supplementary testing (HLA typing) and We will pay the associated supplementary fee

☐ We do not wish to proceed with the supplementary testing (HLA typing) and We understand that if the Stem Cells are requested for use by a relative of the Child further testing may be required in accordance with the regulations in place at the moment of proposed usage.

Signature of mother _____ Signature of father/partner _____

RIGHTS TO THE CHILD'S STEM CELLS IN CASE OF TERMINATION/EXPIRY OF THIS AGREEMENT OR INELIGIBILITY FOR STORAGE.

We understand We may decide at any moment to terminate the storage of the Child's Stem Cells. We will be able to terminate this agreement by providing the Bank with a copy of the "Consent to discontinue storage of frozen cord blood sample: FO-BSC-007" duly signed by all signatories of the present consent or by a person entitled with parental authority or by the Child's legal guardian.

We understand that in the event that We would like to terminate the storage of the Child's Stems Cells or in the case of non payment (expiry of this agreement), We can still have control of the fate of the Child's Stems Cells sample by completing the options concerning their disposition detailed within consent FO-BSC-007.

We understand and accept that if We do not give precise instructions concerning the fate of the Child's Stem Cells within 90 days from the termination/expiry of this agreement the Bank retains the right to discard or use the Child's Stem Cells at its sole discretion, and according to the legislation in force at that moment.

We confirm and accept that if We decide to cease the storage of the Child's Stem Cells, We will not be reimbursed for any portion of the storage fees already paid.

In the event the Bank determines the Child's Stem Cells to be ineligible for storage, it will notify us and request written instructions regarding the disposition of the Child's Stem Cells. If We fail to provide written instructions within 90 days of receiving notification of its ineligibility for storage, the Bank may discard the sample.

RESPONSIBILITY LIMITATION

We understand that in the case of deterioration or the loss of the Child's Stem Cells resulting from a natural catastrophe, an accident, or any other major force or condition out of the Bank's control, the Bank will be free from any responsibility.

We understand that it is possible that the collection device and/or the storage system may fail with the consequence of the loss of the Child`s Stem Cells.

We understand that if the Bank is unable to process and/or store our umbilical cord sample, due to circumstances beyond their control, arrangements are in place to transfer the sample to another cord blood bank for processing and/or storage.

Mother's initials ☐ Father's/Partner's initials ☐

We consent that the Bank (along with its directors, managers, employees and agents) will not be held responsible, according to this consent, for any loss or damage following, directly or indirectly, any action made in all good faith in the realization of its obligation or in any reason other than a deliberate act of negligence from the Bank. In any case, We consent for ourselves and for our Child that the responsibility of the Bank, according to the present consent, is limited to the equal reimbursement of the amount paid by ourselves to the Bank.

APPLICABLE LAW

This consent will apply according to the law in force in the province of Quebec and any conflict regarding this consent, or that occurred from it, will be resolved exclusively by the court of the province of Quebec in Canada.

CONFIDENTIALITY

We understand that all information contained in our file remains confidential as determined by the law and that We have the right to access this information. Only authorized staff of the Bank will have access to this file and these staff are bound by a confidentiality agreement. All files are kept in a contained safe area to ensure confidentiality.

We understand that our medical file will not be disclosed to anyone without our prior written consent, except when such a disclosure is required by law. It may be required to make this information available to Health Canada or another appropriate authority. If identifying information is requested by a transplant unit, our prior consent will be required.

We understand that non-identifying information generated during the processing of our Child's Umbilical Sample (for example, the number of cells present) may be used for quality control assessments or for research purposes.

INFORMED CONSENT

We consent voluntarily to be legally bound to this consent. This consent will be binding on us, our heirs, assigned administrators, guardians, lawyers and trustees.

By signing this consent from, We request, authorize and give our consent to the Bank, its physicians, agents, representatives and employees to process, test, separate, cryopreserve and store the Child's Umbilical Sample. We understand that our acceptance and our consent to participate at this program are completely voluntary.

We certify that We understand the risks and the benefits of the collection and the storage of the Umbilical Sample, that We have been informed about the other available treatments, that We have read the information contained within this document, that We understand the content of this document and that We obtained answers to all questions that We had concerning the terms of this consent.

We voluntarily sign this consent at our wish.

Signed on _____ day of _____ _____

Day Month Year

Mother's name	Mother's signature
Father's/Partner's name	Father's/Partner's signature

Mother's medical questionnaire

Last name as per health card		**First name** as per health card	
Date of birth day-month-year		**Ethnic ancestry**	

Please complete accurately the following confidential medical history questionnaire and send the original back to **ovo biosurance**. At the time of the delivery you will be required to update this information. Based on your medical history and your subsequent infectious disease testing results, you may be required to undergo additional tests to assess your suitability as a candidate for the cord blood storage program. If you are unsure about your medical history, please contact your physician and get them to review this document before sending it back to us. **If you respond yes to one or more questions, please give details in the section at the end.**

	QUESTIONS	MOTHER
1	Are you suffering now from any illnesses including any systemic bacterial, viral or fungal infection?	☐ yes ☐ no
2	In the past 2 years, have you seen a physician or been hospitalized for any medical condition or had a surgery? **(provide dates, name of medical establishment, name of physician and the reason)**	☐ yes ☐ no
3	Have you had any complications in this pregnancy or a previous pregnancy?	☐ yes ☐ no
4	For the actual pregnancy, did you undergo any of the following procedures to get pregnant:	
	a) In vitro fertilization (IVF)?	☐ yes ☐ no
	b) sperm donor and/or egg donor? If so, which one: _____	☐ yes ☐ no
	c) surrogate mother?	☐ yes ☐ no
5	Have you ever tested positive for syphilis, HTLV 1 or 2?	☐ yes ☐ no
6	Have you ever tested positive for HIV, Hepatitis C or Hepatitis B?	☐ yes ☐ no
7	Are you a person who may be at risk for HIV, hepatitis C or hepatitis B? (please indicate if you belong to one of these categories)	
	a. person who reports nonmedical intravenous, intramuscular or subcutaneous injection of drugs in the preceding five years	☐ yes ☐ no
	b. person with hemophilia or related clotting disorder who has received human derived clotting factor concentrates	☐ yes ☐ no
	c. person who has engaged in sex in exchange for money or drugs in the preceding 5 years	☐ yes ☐ no
	d. person who has had sex with a person known or suspected to have HIV, hepatitis B or hepatitis C	☐ yes ☐ no
	e. person who has a history of nasal cocaine use in the last 6 months	☐ yes ☐ no
	f. person who has had sex in the preceding 12 months with any person described in a) to e)	☐ yes ☐ no
	g. person who has had sex with a man who himself has had sex with another man in the preceding 12 months	☐ yes ☐ no

Last name :	First name :	
	h. person who, in the preceding 12 months, has been exposed to blood, body fluids or a needle infected or suspected to be infected with HIV, hepatitis B or hepatitis C, through percutaneous inoculation or through contact with an open wound, non-intact skin, or mucous membrane	☐ yes ☐ no
8	Have you ever been in a correctional facility, juvenile detention center, prison, psychiatric institution or jail for more than 72 consecutive hours during the previous 12 months?	☐ yes ☐ no
9	Have you had any tattoo, acupuncture, ear or body piercing in the past 12 months, using unsterilized equipment (use of contaminated instruments or ink, instruments not sterilized between uses, etc.)?	☐ yes ☐ no
10	Based on your family history, occupation, lifestyle, do you consider yourself to be at risk for HIV or Hepatitis B or C?	☐ yes ☐ no
11	In the last 12 months, have you been in close contact with anyone with clinically active viral hepatitis? (e.g. living in the same household, where sharing of the kitchen and bathroom facilities occurs regularly)	☐ yes ☐ no
12	Have you ever been diagnosed any prion related disease such as Creutzfeldt-Jakob disease (CJD), variant CJD, Gertsmann-Staüssler-Scheinker syndrome or any other transmissible spongiform encephalopathies?	☐ yes ☐ no
13	Have you ever been diagnosed with the following diseases: malaria, babesiosis, Chagas disease, Leishmaniasis, West Nile Virus, Lyme disease, or any blood borne parasitic disease?	☐ yes ☐ no
14	Have you ever been diagnosed with a brain tumor or a neurodegenerative disease such as dementia, Alzheimer, Parkinson's, subacute sclerosing panencephalitis (SSPE), progressive multifocal leukoencephalopathy, amyotrophic lateral sclerosis (ALS) or an infection such as encephalitis or meningitis of viral, bacterial or unknown etiology?	☐ yes ☐ no
15	Have you ever been diagnosed with tuberculosis (TB) or SARS or exposed to TB or SARS?	☐ yes ☐ no
16	Have you recently exhibited unexplained weakness, fatigue, nausea, diarrhea, weight loss, swollen lymph glands, persistent fever or cough, night sweats or purple spots on the skin?	☐ yes ☐ no
17	Have you ever been diagnosed with rabies or within the past 6 months, been bitten by an animal and treated as if the animal was rabid?	☐ yes ☐ no
18	Have you ever been diagnosed with a blood or bleeding disorder?	☐ yes ☐ no
19	Have you ever received human-derived pituitary growth hormone or Dura mater? If so when and in which country did you receive it?	☐ yes ☐ no
20	In the past 12 months, have you received a blood transfusion or any blood components, bone marrow or clotting factors for hemophilia or had a tissue or organ transplant? If yes, please provide details.	☐ yes ☐ no
21	Have you ever been refused as a blood, bone marrow, organ donor or to store your baby's umbilical cord blood? (if yes, please provide the reason)	☐ yes ☐ no
22	Do you currently take or have taken in the past 2 years, any prescribed medications other that vitamins, mineral supplements or Diclectin? **If yes, please list all medications used and the reasons for their use.**	☐ yes ☐ no
23	Have you been vaccinated against hepatitis B in the last 5 years?	☐ yes ☐ no
24	Have you ever received the vaccinia vaccine (against smallpox)?	☐ yes ☐ no
25	Have you had any vaccinations in the past 3 months? If yes, please provides which ones and when.	☐ yes ☐ no

Last name :	First name :	
26	Have you ever been investigated or diagnosed for any heart, lung, liver, kidney, bone, bowel or any other chronic disease? Is so, which one(s)? (if hospitalization was required provide dates, medical institution)	☐ yes ☐ no
27	In the last 12 months, have you been diagnosed or treated for syphilis, gonorrhea, genital herpes, Chlamydia, trichomonas or any other sexually transmitted disease?	☐ yes ☐ no
28	Have you ever been diagnosed or investigated for any autoimmune or chronic degenerative disease? (E.g. lupus, rheumatoid arthritis, multiple sclerosis, myasthenia gravis, polyarteritis nodosa or sarcoidosis).	☐ yes ☐ no
29	In the past 3 years, have you traveled or lived outside of Canada? **(please provide dates and countries visited)**	☐ yes ☐ no
30	Have you ever been treated for a travel-related illness after returning home from travel?	☐ yes ☐ no
31	Have you ever lived, traveled or received medical treatment in Africa?	☐ yes ☐ no
32	Have you spent a total of three or more months in Europe since January 1980?	☐ yes ☐ no
33	Have you received a blood transfusion or treatment with blood product in Europe since January 1980?	☐ yes ☐ no
34	Have you been diagnosed with Zika virus infection at any point in your pregnancy or had sexual relations at any time in your pregnancy with a male who is known to have had a medical diagnosis of Zika virus infection within six months prior to the sexual contact or who has resided in, or travelled to an area with active Zika virus transmission within the past six months?	☐ yes ☐ no
35	Have you ever been diagnosed with a genetic disease? (Including blood diseases such as sickle cell anemia, thalasemia, aplastic anemia, Fanconi's anemia, hemophilia, or immune deficiency syndromes or metabolic storage diseases such as Hunter or Hurler syndromes).	☐ yes ☐ no
36	Have you ever taken insulin? If yes, please indicate the dates and what type of insulin.	☐ yes ☐ no
37	Have you ever been diagnosed with cancer of the breast, ovary, uterus, liver, bowel, blood (e.g. leukemia), lymph glands (e.g.lymphoma), skin (e.g. melanoma) or any other type of cancer?	☐ yes ☐ no
38	Are you (the mother) or the father of the new-born adopted? If yes, please indicate whether you have access to the medical and genetic history of the biological parents.	☐ yes ☐ no
39	Has anyone in the new-born's family (father, brother, sisters, aunts, uncles and grand-parents **of the new-born**) ever been: If the response is yes, please give details of the illness and the person affected.	
	a. been affected or is affected with a neurological disease, a prion related disease, an active encephalitis or meningitis?	☐ yes ☐ no
	b. diagnosed with rabies or within the past 6 months, been bitten by an animal and treated as if the animal was rabid?	☐ yes ☐ no
	c. infected with HIV, active hepatitis B, hepatitis C, HTLV, syphilis or West Nile virus?	☐ yes ☐ no
	d. diagnosed with breast, ovarian, uterine, prostate, liver, or bowel cancer or a cancer of the blood or lymph glands?	☐ yes ☐ no
	e. diagnosed with a genetic disease?	☐ yes ☐ no
	f. received human-derived pituitary growth hormone or Dura mater? If so when and in which country.	☐ yes ☐ no
40	Has anyone in the new-born's family has been affected or is affected with Creutzfeldt-Jakob disease (mad cow disease)?	☐ yes ☐ no

Please indicate the question number and give an explanation for each YES answer. Use an additional sheet of paper if necessary.	
#	**DETAILS**

INFORMED CONSENT FOR THE MEDICAL QUESTIONNAIRE

Safety of blood and blood components is of paramount importance. We want you to be aware that the decision on who can or cannot use the cord blood will be dependent on your medical history and subsequent blood test results. The use of this cord blood by any individual other than the original donor (your child) may require additional screening and/or blood testing of the birth mother and/or donor, and will be subject to compliance with Health Canada regulations prevalent at the time of usage. Please call us if you need any further clarification.

I certify that I have read all the above statements and have answered all the above questions truthfully and to the best of my knowledge.	
Mother's signature	**Date: day-month-year**

IDENTIFICATION

Section to be completed by the doctor/midwife

Dear parents,

Health Canada Regulations relating to Basic Safety Requirements for Human Cells, Tissues and Organs for transplantations stipulate that all donors must undergo a basic physical examination to qualify for Cord Blood Banking. **Please note that this document must be completed within the 30 days before the delivery date.** Without this physical examination completed within the required delay, the umbilical cord blood sample could have its eligibility limited.

The following section should be completed by the birth mother

I _____ authorize the following health professional: _____ to release the information pertaining to my medical care.

Mother's signature	Date: *(day-month-year)*

The following section must be completed by the health professional who follows your pregnancy

Has the above named patient ever tested positive for one of the following conditions:

HIV	☐ yes	☐ no	☐ not tested
HEPATITIS B	☐ yes	☐ no	☐ not tested
HEPATITIS C	☐ yes	☐ no	☐ not tested
SEXUALLY TRANSMITTED DISEASE	☐ yes	☐ no	☐ not tested

During the examination of the above named patient, did you find any physical signs that would suggest:

HIGH RISK BEHAVIOUR *(Such as needle tracks suggesting nonmedical percutanous drug use)*	☐ yes	☐ no
MALIGNANCY	☐ yes	☐ no
BACTERIAL OR VIRAL INFECTION	☐ yes	☐ no

If yes, please give details: _____

Name of Health Professional	Signature of Health Professional	Date: *(day-month-year)*