IMPORTANT: In accordance with Health Canada Guidance (July 2005) INCOMPLETE FORMS CANNOT BE PROCESSED

CANADIAN CORD BLOOD bioREPOSITORY
18228 102 Avenue NW
Edmonton, AB T5S 1S7
Tel: 1(888) 818-2673

AUTOLOGOUS (SELF) CORD BLOOD STORAGE REGISTRATION FORM

A. MOTHER'S INFORMATION (Mother of unborn baby) Dr. ☐ Ms. ☐ Mrs. ☐ Miss. ☐

Surname: _____ Given Names: _____

Date of Birth: _____ (Day/Month/Year) Age at Conception: _____ (Years & Months) Expected Due Date: _____ (Day/Month/Year)

Provincial Healthcare No.: _____ **(Mandatory for sample identification only)**

Multiple Births YES ☐ NO ☐ Planned C-Section YES ☐ NO ☐ Previously stored with our Bank YES ☐ NO ☐

Permanent Mailing Address: **(Notify Bank of any address changes)**

Apartment No./Street: _____ Home Phone: ( ) _____

City/Town: _____ Home Fax: ( ) _____

Province: _____ Postal Code: _____ Work Phone: ( ) _____

E-mail: _____ Cell Phone: ( ) _____

B. FATHER'S INFORMATION (Father of unborn baby)

Full Name: _____ (Surname First Middle) Date of Birth: _____ (Day/Month/Year)

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work No.: ( ) _____ E-mail: _____

CHECK LIST

- ☐ Read Information Brochure and Fee Schedule Information
- ☐ Read completely through the Health Questionnaire. If **NONE** of the exclusionary criteria (Red Check Boxes) apply, proceed with registration.
- ☐ Health Questionnaire Fully Completed
- ☐ Explanation of YES answers where not indicated as exclusionary...provide date if applicable
- ☐ Health Care Number entered
- ☐ Delivery Unit Telephone and Fax Number entered
- ☐ Informed Consent completed by and signed by both parents of the baby
- ☐ Physician/ Midwife certification signed (Form can be accepted without this and we will take care of it)
- ☐ Original application will be **RECEIVED** at **CCBR** by **MAIL** before the end of the 36th. week of pregnancy
- ☐ Payment enclosed (Full amount of $860.00 or Payment Plan of $250.00 and 3 post dated cheques for $205.00. Post dated cheques are for 1 month after the first cheque and 1 month after each other)
- ☐ How did you hear about us?
  Physician __ Facebook __ Instagram__ Referral__
  Online recommendation __ Local business __ Mail__
  Email __ Website __ Google Search __ Other _____

Please MAIL completed form to the above address before the end of the 36th. week of your pregnancy.

COLLECTION SITE AND MEDICAL PERSONNEL INFORMATION

C. DELIVERY INSTITUTION (Labour and Delivery Hospital)

_____
(Name of Delivery Institution)

Delivery Unit Phone: ( ) _____ Delivery Unit Fax: ( ) _____

Hospital Phone: ( ) _____

D.☐ ATTENDING DELIVERY PHYSICIAN OR☐ MIDWIFE

Surname: _____ Name and Initial: _____

Address: _____ Office Phone: ( ) _____

Street: _____ Office Fax: ( ) _____

City / Town: _____ Email: _____
(If Available)

Province: _____ Postal Code: _____

E. FAMILY PHYSICIAN / PEDIATRICIAN: (Health care provider for the new baby, if known)

_____
(Surname First Initial)

Office Phone: ( ) _____ Office Fax: ( ) _____

Email: _____
(If Available)

Instructions for the completion of this form:

Sections A & B: Required to ensure that the cord blood unit is correctly identified for future access.
Section C: Important for the correction of any errors or omissions at the time of cord blood collection.
Section D: Required to inform your delivering physician (group of physicians) or midwife that you have registered for autologous storage.
Section E: This area may be used to contact your newborn's physician in the future.
Section F: Health Questionnaire - serves as a history of the cord blood unit. This information is particularly important if the cord blood unit is used to transplant another family member other than the child from whom it has been collected. Answer all questions honestly and to the best of your ability. If you have questions, please contact us.
Section G: This area ensures that you have had all your questions answered and are in a position to make an informed decision regarding the expectations and responsibilities of cord blood storage.
Section H: The Canadian Cord Blood bioRepository is unable to interview each applicant in person. This area allows for your physician/midwife to certify that the answers given are true and correct to the best of their ability to make this determination.

Thank you for storing with the Canadian Cord Blood bioRepository.
Both you and your physician will be notified of your confirmation as a registered cord blood storer.

F. AUTOLOGOUS/FAMILY UMBILICAL CORD BLOOD STORAGE HEALTH QUESTIONNAIRE

(The following information is required by the Canadian Cord Blood bioRepository in compliance with regulations governing the donation of umbilical cord blood for related and unrelated transplantation in Canada)

YES ANSWER IN ANY RED CHECK BOX ◇X◇ EXCLUDES FROM STORAGE

	MOTHER		FATHER	
DURING THIS PREGNANCY...(if yes and not indicated as exclusionary, please explain)	NO	YES	NO	YES
1. Prior to this pregnancy did you have any health issues?	☐	☐	☐	☐
2. Has there been any history of illnesses (excludes colds) or complications of pregnancy (including gestational diabetes)?	☐	☐	☐	☐
3. Have you had prescribed medications for any reason, with the exception of vitamins, iron supplements or Diclectin?	☐	☐	☐	☐
4. Did conception occur before the mother's 18th. birth date?	☐	☐		
5. Did conception result from an In-Vitro Fertilization using either donor sperm, donor ovum or surrogacy?	☐	☐		
6. Have either of you been diagnosed with malaria, been infected with West Nile virus or SARS?	☐	◇	☐	◇
7. Have you had any of the following systemic infections: bacterial, viral or fungal?	☐	☐	☐	☐
IN THE FAMILY...(if yes and not indicated as exclusionary, please explain)				
8. Is there a history of inherited genetic disease including inheritable blood or bleeding disorders (hemophilia, sickle cell thalassemia), immune deficiencies or metabolic storage diseases?	☐	☐	☐	☐
9. Is there a history of acquired immune deficiencies or blood disorders (eg. leukemia, lymphoma or other blood cancers)?	☐	☐	☐	☐
10. Is there a history of consanguinity (blood related marriages of parents or grandparents up to first cousins)?	☐	☐	☐	☐
11. Is there a history of early childhood deaths?	☐	☐	☐	☐
12. Have either of the parents or grandparents of the baby been adopted?	☐	☐	☐	☐
13. Has either parent (Mother or Father of the baby) been involved in the sex trade (sex in exchange for money or drugs)?	☐	◇	☐	◇
14. Has anyone been diagnosed with SSPE (subacute sclerosing panencephalitis)?	☐	☐	☐	☐
HAVE YOU EVER...(if yes and not indicated as exclusionary, please explain)				
15. Had a health issue requiring major medical or surgical intervention?	☐	☐	☐	☐
16. Had Creutzfeld-Jakob Disease (CJD) or had a family member (a blood relative) with CJD?	☐	☐	☐	☐
17. Had Chagas Disease or Babesiosis?	☐	◇	☐	◇
18. Spent a cumulative period of time of 3 months or more in the United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, or the Channel Islands) or France from January 1, 1980 to December 31, 1996?	☐	☐	☐	☐
19. Spent a total of five years or more in any European country since January 1, 1980?	☐	☐	☐	☐
20. Received a blood transfusion or a blood component in the United Kingdom, France or elsewhere in Europe, since 1980?	☐	☐	☐	☐
21. Received an organ transplant of any kind, including skin graft?	☐	☐	☐	☐
22. Been treated with dura mater or a pituitary growth hormone of human origin?	☐	☐	☐	☐
23. Had viral hepatitis, yellow jaundice, liver disease or had a positive or a false positive test of any type at any time for hepatitis B or C?	☐	◇	☐	◇
24. Had clinical or laboratory evidence (a positive or a false positive test of any type at any time) of HIV, HTLV or syphilis?	☐	◇	☐	◇
25. Had AIDS or any of its' complications, (progressive multifocal leukoencephalopathy or lymphoma); had a sexual partner who has had HIV-AIDS or any of its complications or have been at risk for AIDS (you may have been at risk if you are a blood clotting factor recipient, have taken illegal drugs by injection, or have had multiple sexual partners, or a sexual partner who has had multiple partners)? ***For additional risk factors please see top of Page 4**	☐	◇	☐	◇
26. Had sexual contact with a male who has had sexual contact with another male, even once, since 1975?	☐	☐	☐	☐
27. Had sexual contact with another person whose background is uncertain?	☐	☐	☐	☐
28. Been refused as a blood donor in Canada?	☐	☐	☐	☐
29. Received a transfusion of whole blood, plasma or plasma derived clotting factors (excludes Rhogam and WinRho)?	☐	☐	☐	☐
30. Been an inmate of a correctional institution?	☐	☐	☐	☐
IN THE PAST YEAR (prior to date of conception) HAVE YOU...(if yes, please explain)				
31. Received blood components or a tissue or organ transplant of any kind including skin graft?	☐	☐	☐	☐
32. Shown evidence of or been treated for chlamydia, genital herpes, syphilis or any other sexually transmitted disease?	☐	☐	☐	☐
33. Been exposed to anyone with hepatitis or yellow jaundice?	☐	☐	☐	☐
34. Had a tattoo, body piercing, acupuncture, electrolysis, needle stick injury, serious human bite or come into contact with someone else's blood?	☐	☐	☐	☐
IN THE PAST THREE YEARS (prior to date of conception) HAVE YOU...(if yes and not indicated as exclusionary, Please explain)				
35. Travelled outside of Canada or the Continental United States?	☐	☐	☐	☐
36. Been treated for malaria or rabies?	☐	◇	☐	◇
37. Been treated for any other travel related illness after your return to Canada?	☐	☐	☐	☐
IMMUNIZATIONS and/or VACCINATIONS: HAVE YOU...(if yes and not exclusionary, please explain)				
38. Received a live (attenuated) vaccine **within 6 weeks of the date of conception or at any time during** this pregnancy? (small pox, yellow fever, chicken pox (varicella), rubeola (measles)/mumps, rubella(MMR), oral polio, or live attenuated flu vaccine)	☐	☐	☐	☐
39. Had contact with a person who has had any of the vaccines listed in #38 **within 6 weeks of the date of conception or at any time during** this pregnancy? (Examples of contact include physical intimacy, touching the site of vaccination site, touching bandages or handling clothing and bedding which have been in contact with an open vaccination site.)	☐	☐	☐	☐
40. Received immune globulin for prevention of hepatitis B after an exposure **within 6 months of date of conception or during this pregnancy?**	☐	◇	☐	◇
41. Received a killed virus vaccine ("flu shot") at anytime during this pregnancy?	☐	☐	☐	☐

*** Persons at Risk for HIV/AIDS**

1. Men who have had sex with men after 1975
2. Men and women having unprotected sex with multiple partners
3. Injection drug users
4. Men and women who exchange sex for money or have partners who do
5. Individuals whose past or present sex partners were HIV infected, bisexual, or injection drug users
6. Persons who were treated for another sexually transmitted disease
7. Persons with a history of blood transfusions between 1975 and 1985
8. Individuals who are or have been in correctional institutions

PLEASE EXPLAIN ANY "YES" ANSWERS TO THE QUESTIONS
(Record the question number; use additional pages for responses if required)

G. INFORMED CONSENT

I certify that:

1. I have read the Information Brochure/Webpage of the Canadian Cord Blood bioRepository and have had all of my questions answered to my complete satisfaction.
2. The information that I have provided on this form is complete and truthful to the best of my knowledge.
3. I will allow my doctor or my baby's doctors to provide relevant and specific health information that might impact the quality and safety of the cord blood in storage.
4. I agree to pay all fees associated with the storage of this umbilical cord blood sample on behalf of my family. I understand that $250.00 of the fees are non-refundable following the successful registration. Fee is fully refundable if this application for storage is unsuccessful.
5. I understand that, should I indicate (by **notarized letter** signed by all guardians of the child) that I no longer wish to store cord blood stem cells privately with the CANADIAN CORD BLOOD BIOREPOSITORY, the stored cord blood unit may be transferred to the public sector or destroyed.

I hereby give my informed consent to the Canadian Cord Blood bioRepository, to its Board of Directors, and to my physician/midwife for the collection of umbilical cord blood at the delivery of my baby.

(Signature of Mother)	(Print Name of Mother)	(Date)
(Signature of Father)	(Print Name of Father)	(Date)

H. PHYSICIAN CERTIFICATION: (New guidelines by Health Canada stipulate that this procedure shall be undertaken by the Ob-Gyn/Family Physician/Midwife prior to acceptance into this program.)

Having physically examined,_____ , and after having reviewed the Health Questionnaire and her medical records, I do hereby certify that she has no physical signs to suggest present or past HIGH RISK BEHAVIOUR for transmissible infectious diseases (HIV, HTLV, hepatitis B or C and sexually transmitted diseases) and that all responses to the Health Questionnaire are accurate to the best of my knowledge. I understand that the foregoing criteria will determine the eligibility of this mother to store her infant's cord blood at birth with the Canadian Cord Blood bioRepository. In the event that new health information that might impact the collection becomes available, I undertake to provide such information to the Canadian Cord Blood bioRepository.

(Signature of Physician/Midwife)	(Print Name of Physician/Midwife)	**(Date)**