Canadian Blood Services BLOOD PLASMA STEM CELLS ORGANS & TISSUES

Cord Blood Medical History/ Health Assessment Questionnaire

Maternal Hospital ID Label

☐ OTT ☐ BRM ☐ EDM ☐VAN

Date: YYYY / MM / DD	Phone Interview ☐ (if applicable)
Informed Consent on file ☐	

**** Mandatory fields***

GENERAL INFORMATION			
***Last Name** As per government ID			
***First Name** As per government ID			
***DOB**	YYYY / MM / DD	***Phone #**	( )
Email (if avail)		**Mobile#** **(if avail)**	( )

***Home Address** (#, Street)**:**		
***City:**	***Province**	***Postal Code**
Name of Doctor/Midwife (if avail):	**Phone Number of Doctor/Midwife (if avail):**	
Name of Family Doctor (if avail):	**Phone Number of Family Doctor (if avail):**	
Change of Information: ☐ Name ☐ Address ☐ Phone Number ☐ Postal Code		

Donation History		
Have you ever donated or attempted to donate blood, a blood product, stem cells or umbilical cord blood at Canadian Blood Services or HemaQuebec using your current name or a different name? ☐CBS ☐HQ	☐ Yes	☐ No
Have you ever been deferred or refused as a blood donor, stem cell donor or umbilical cord blood donor by Canadian Blood Services or HemaQuebec?	☐ Yes	☐ No

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Check (√) the item(s) below that best describes mother, the father and grandparents of the baby, if known.

	Mother	Grand Mother	Grand Father		Father	Grand Mother	Grand Father
Arab							
Asian-Central							
Asian-North							
Asian-Northeast							
Asian-South							
Asian-Southeast							
Black-African							
Black-Caribbean							
Black-Other							
Caucasian/White							
Chinese							
Filipino							
First Nations							
Hispanic							
Inuit							
Jewish-Ashkenazi							
Jewish-Sephardic							
Metis							
Pacific Islander							
Multiple Ethnicity							
Unknown							

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PREGNANCY HISTORY			
1.	Did conception result from fertilization using a donor sperm, donor egg, or surrogacy?	☐ Yes	☐ No
2.	Have you had any complications with this pregnancy or any previous pregnancies?	☐ Yes	☐ No
3.	Have you had any infections with this pregnancy: bacterial, fungal or viral?	☐ Yes	☐ No
4.	During your pregnancy, have you been diagnosed with West Nile Virus or had a positive test for West Nile Virus?	☐ Yes	☐ No
5.	Have you had any abnormal result from a prenatal test? (i.e. amniocentesis, blood test or ultrasound)	☐ Yes	☐ No
6.	Do you have Type 1 diabetes?	☐ Yes	☐ No
7.	Have you used Insulin prior to 2007-01-01 daily for at least 6 months?	☐ Yes	☐ No
8.	Have you taken any medications within the last 7 days other than vitamins and iron?	☐ Yes	☐ No
9.	Do you have any life threatening allergies?	☐ Yes	☐ No
MOTHER'S MEDICAL HISTORY			
10.	In the past 12 months have you had any medical issues or investigations?	☐ Yes	☐ No
11.	In the past 6 months have you received a blood transfusion, or any other blood product or component including medications for Rh incompatibility?	☐ Yes	☐ No
12.	Have you ever taken human pituitary growth hormone?	☐ Yes	☐ No
13.	Have you received a Rabies vaccination in the past 12 months?	☐ Yes	☐ No
14.	In the last 6 months have you been bitten by an animal and treated as if the animal had rabies?	☐ Yes	☐ No

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15.	In the past 3 months, have you had any shots or vaccinations?	☐ Yes	☐ No
16.	Have you ever had any type of cancer, including leukemia or lymphoma?	☐ Yes	☐ No
17.	Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia?	☐ Yes	☐ No
18.	Have you had yellow jaundice, liver disease or viral hepatitis?	☐ Yes	☐ No
19.	Have you ever received a Dura mater (brain covering) graft?	☐ Yes	☐ No
20.	Have you or any of your blood relatives (parents, sibling) ever been diagnosed with Creutzfeldt-Jakob disease (CJD), variant CJD, or other neurological disease where the cause is unknown?	☐ Yes	☐ No
21.	Have you had a transplant or tissue graft from someone other than yourself, such as organ, bone marrow, stem cell, cornea, bone or tissue?	☐ Yes	☐ No
22.	Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?	☐ Yes	☐ No
23.	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
24.	Have you ever had a parasitic blood disease (for example, Leishmaniasis, Babesiosis, or Chagas Disease) or any positive tests for Chagas or T.cruzi, including screening tests?	☐ Yes	☐ No
25.	Have you ever had malaria?	☐ Yes	☐ No
26.	In the past 3 years have you travelled outside of Canada other than the US?	☐ Yes	☐ No

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MOTHER'S TRAVEL HISTORY

Reference Chart for Questions 27-31: Countries considered at risk for vCJD

Albania	Finland	Luxembourg	Slovak Republic
Austria	France	Macedonia	Slovenia
Belgium	Germany	Netherlands (Holland)	Spain
Bosnia-Herzegovina	Greece	Norway	Sweden
Bulgaria	Hungary	Poland	Switzerland
Croatia	Ireland (Republic of)	Portugal	Turkey
Czech Republic	Italy	Romania	Yugoslavia (Federal Republic of): Kosovo, Montenegro, Serbia
Denmark	Liechtenstein	San Marino	
		Saudi Arabia	

United Kingdom (UK): England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands

27.	**Since 1980**, have you ever lived in, or travelled to any country considered to be at risk for transmission of vCJD (variant Creutzfeldt-Jakob Disease)? **If NO, proceed to question 32.**	☐ Yes	☐ No
28.	**From 1980-1996**, did you spend time that **adds up to 3 months or more**, in the United Kingdom or France?	☐ Yes	☐ No
29.	Have you spent a total of 6 months or more in Saudi Arabia from January 1, 1980 through to December 31, 1996?	☐ Yes	☐ No
30.	**Since 1980** have you received a transfusion of blood or blood products while in the UK or France or elsewhere in Europe?	☐ Yes	☐ No
31.	**Since 1980** have you spent time that **adds up to 5 years or more** (including time spent in the UK from 1980-1996), in any country considered to be at risk for vCJD (variant Creutzfeldt-Jakob Disease)?	☐ Yes	☐ No
32.	Have you been diagnosed with a ZIKA infection at any point during this pregnancy?	☐ Yes	☐ No
33.	Have you resided, or travelled to, an area with active ZIKA transmission at any point during this pregnancy?	☐ Yes	☐ No
34.	Have you had sex at any point during this pregnancy with a person who is known to have either of the risk factors listed: i. medical diagnosis of ZIKA infection in the past 6 months ii. residence in, or travel to, an area with active ZIKA transmission within the past 6 months.	☐ Yes	☐ No

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FAMILY MEDICAL HISTORY			
35.	Are you and the baby's father siblings or first cousins?	☐ Yes	☐ No
36.	Were you and/or the baby's father adopted at birth or early childhood? If yes, ☐ mother ☐ father ☐ both	☐ Yes	☐ No
	Is there a known family history (blood relatives) of the following:		
37.	**Red Blood cell disease** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
38.	**White Blood cell disease** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
39.	**Platelet disease** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
40.	**Metabolic/storage disease** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
41.	**Congenital Immune Disorders (Immunodeficiencies)** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
42.	**Acquired Immune Disorders** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
43.	**Malignant blood disorders** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
44.	**Other Cancers** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No
45.	**Other Blood Disease or Medical Disorders** ☐ Baby's mother ☐ Baby's father ☐ Baby's sibling ☐ Baby's aunts/uncles ☐ Baby's grandparents	☐ Yes	☐ No

CBU Unique ID

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MOTHER'S SOCIAL HISTORY			
46.	In the past 12 weeks, have you had contact with someone who had a smallpox vaccination?	☐ Yes	☐ No
47.	In the past 6 months, have you had a tattoo, ear or body piercing, acupuncture, electrolysis or any procedure involving needles?	☐ Yes	☐ No
48.	In the past 6 months, have you had an injury from a needle or come into contact with someone else's blood through an open wound, non-intact skin, or mucous membrane?	☐ Yes	☐ No
49.	In the past 12 months, have you had or been treated for **any** sexually transmitted disease including syphilis or gonorrhea?	☐ Yes	☐ No
50.	In the past 12 months, have you had sex with anyone who has accepted or paid money or drugs for sex in the **past 5 years**?	☐ Yes	☐ No
51.	In the past 12 months, have you had close contact, such as living in the same household or sharing kitchen and bathroom facilities, with a person who has clinically active viral hepatitis or yellow jaundice?	☐ Yes	☐ No
52.	In the past 12 months, 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
53.	In the past 12 months, have you used cocaine?	☐ Yes	☐ No
54.	In the past 12 months, have you had sex with a male who has had sex with another male, even once in the **past 12 months?**	☐ Yes	☐ No
55.	In the past 12 months, have you had sex, even once, with anyone who has taken human-derived clotting factors for a bleeding problem such as hemophilia?	☐ Yes	☐ No
56.	In the past 12 months have you had sex, even once, with a person known or suspected to have HIV, a positive test for the AIDs virus, clinically active Hepatitis B Virus or Hepatitis C Virus or who has ever been diagnosed with Hepatitis B or Hepatitis C Virus?	☐ Yes	☐ No
57.	In the past 12 months, have you been in youth correctional facility, jail or prison for **more than 72 consecutive** hours?	☐ Yes	☐ No
58.	In the **past 5 years**, have you accepted or paid money or drugs for sex?	☐ Yes	☐ No
59.	In the **past 5 years**, have you used a needle, even once, to take drugs, steroids, or anything else not prescribed for you by a doctor?	☐ Yes	☐ No
60.	Do you have AIDS or have you ever tested positive for HIV or AIDS (including screening tests)?	☐ Yes	☐ No
61.	Have you ever tested positive for HTLV (including screening tests) or had unexplained paraparesis (partial paralysis affecting the lower limbs)? HTLV refers to the Human T-cell Lymphotrophic Virus?	☐ Yes	☐ No

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Completed By:

RN Signature:	
Date:	YYYY / MM / DD

Section 1: Reviewer Comments, if applicable (initial and date each entry). Document question # if applicable.

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Section 2: **Risk Factors,** if applicable (initial and date each entry) Document question # (if applicable) and reason.

Section 3: Medical Consult Required (if applicable)		
Consult Medical ☐	Eligible, Unusual Finding, Consult Medical ☐	
Date: YYYY / MM / DD	**RN Initials:**	
Review of Medical Decision *(Supporting documentation attached)*		
Eligible ☐	Eligible, Unusual Finding, ☐	Defer ☐
Date: YYYY / MM / DD	**RN Initials:**	

CBU Unique ID

RESTRICTED

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Section 4: Deferral Notification, if applicable		
Notification Attempt #1	Date: YYYY / MM / DD	**RN Initials:**
Notification Attempt #2 (if applicable)	Date: YYYY / MM / DD	**RN Initials:**
Note (if applicable)		
Unable to contact mother for notification ☐ If applicable	Date: YYYY / MM / DD	**RN Initials:**

Section 5: Final Eligibility	
Eligible ☐	**Eligible, Unusual Finding** ☐
Defer ☐ (if applicable) *Select all deferral reasons that apply.* ☐ Language Barrier ☐ Maternal Medical/Genetic History ☐ Family Medical/Genetic History ☐ Mother's Social History ☐ Declined CB-MHHAQ and/or BW ☐ Mother's Travel History ☐ Unable to Obtain Maternal Samples	
Notification from MF of Non Qualifying Unit ☐ (If applicable)	Mother Notified of Deferral ☐ or Non Qualifying Unit, if applicable
Chart Review Form Attached, if applicable ☐	
Date: YYYY / MM / DD	**RN Signature:**
2nd RN Reviewer/Initials: _____	Date: YYYY / MM / DD
QER# (if applicable):	