



Maternal Hospital ID Label
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## Cord Blood Medical History/ Health Assessment Questionnaire

OTT    BRM    EDM    VAN

<b>Date:</b> YYYY / MM / DD	Phone Interview <input type="checkbox"/> (if applicable)
Informed Consent on file <input type="checkbox"/>	

**\* Mandatory fields**

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

<b>*Home Address (#, Street):</b>		
<b>*City:</b>	<b>*Province</b>	<b>*Postal Code</b>
<b>Name of Doctor/Midwife (if avail):</b>	<b>Phone Number of Doctor/Midwife (if avail):</b>	
<b>Name of Family Doctor (if avail):</b>	<b>Phone Number of Family Doctor (if avail):</b>	
<b>Change of Information:</b> <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Phone Number <input type="checkbox"/> 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? <input type="checkbox"/> CBS <input type="checkbox"/> HQ	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have you had any complications with this pregnancy or any previous pregnancies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you had any infections with this pregnancy: bacterial, fungal or viral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	During your pregnancy, have you been diagnosed with West Nile Virus or had a positive test for West Nile Virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Have you had any abnormal result from a prenatal test? (i.e. amniocentesis, blood test or ultrasound)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Do you have Type 1 diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Have you used Insulin prior to 2007-01-01 daily for at least 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you taken any medications within the last 7 days other than vitamins and iron?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Do you have any life threatening allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MOTHER'S MEDICAL HISTORY			
10.	In the past 12 months have you had any medical issues or investigations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	In the past 12 months have you received a blood (blood products) transfusion including medications for Rh incompatibility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Have you ever taken human pituitary growth hormone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Have you received a Rabies vaccination in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	In the last 6 months have you been bitten by an animal and treated as if the animal had rabies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	In the past 3 months, have you had any shots or vaccinations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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16.	Have you ever had any type of cancer, including leukemia or lymphoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18.	Have you had yellow jaundice, liver disease or viral hepatitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19.	Have you ever received a Dura mater (brain covering) graft?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25.	Have you ever had malaria?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26.	In the past 3 years have you travelled outside of Canada other than the US?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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,
Denmark	Liechtenstein	San Marino	Montenegro, Serbia
		Saudi Arabia	
United Kingdom (UK): England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands			
27.	<b>Since 1980</b> , have you ever lived in, or travelled to any country considered to be at risk for transmission of vCJD (variant Creutzfeldt-Jakob Disease)? <b>If NO, proceed to question 32.</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28.	<b>From 1980-1996</b> , did you spend time that <b>adds up to 3 months or more</b> , in the United Kingdom or France?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29.	Have you spent a total of 6 months or more in Saudi Arabia from January 1, 1980 through to December 31, 1996?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30.	<b>Since 1980</b> have you received a transfusion of blood or blood products while in the UK or France or elsewhere in Europe?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31.	<b>Since 1980</b> have you spent time that <b>adds up to 5 years or more</b> (including time spent in the UK from 1980-1996), in any country considered to be at risk for vCJD (variant Creutzfeldt-Jakob Disease)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32.	Have you been diagnosed with a ZIKA infection at any point during this pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33.	Have you resided, or travelled to, an area with active ZIKA transmission at any point during this pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
34.	Have you had sex at any point during this pregnancy with a male 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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



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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
47.	In the past 12 months, have you had a tattoo, ear or skin piercing, acupuncture, electrolysis or any procedure involving needles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
48.	In the past 12 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
49.	In the past 12 months, have you had or been treated for <b>any</b> sexually transmitted disease including syphilis or gonorrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>past 5 years?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>past 5 years?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
53.	In the past 12 months, have you used cocaine?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>past 12 months?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
57.	In the past 12 months, have you been in youth correctional facility, jail or prison for <b>more than 72 consecutive</b> hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
58.	In the <b>past 5 years</b> , have you accepted or paid money or drugs for sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
59.	In the <b>past 5 years</b> , have you used a needle, even once, to take drugs, steroids, or anything else not prescribed for you by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
60.	Do you have AIDS or have you ever tested positive for HIV or AIDS (including screening tests)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Lymphotropic Virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Completed By:

<b>RN Signature:</b>	
<b>Date:</b>	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.

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**Section 3: Medical Consult Required** (if applicable)

Consult Medical <input type="checkbox"/>	Eligible, Unusual Finding, Consult Medical <input type="checkbox"/>	
Date:    YYYY / MM / DD	RN Initials:	
Review of Medical Decision <i>(Supporting documentation attached)</i>		
Eligible <input type="checkbox"/>	Eligible, Unusual Finding, <input type="checkbox"/>	Defer <input type="checkbox"/>
Date:    YYYY / MM / DD	RN Initials:	



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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 <input type="checkbox"/> If applicable	Date: YYYY / MM / DD	RN Initials:

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