

Client Information



COMPLETE THIS FORM POST DELIVERY AND RETURN WITH LABELED SPECIMENS, IF YOU HAVE ANY QUESTIONS PLEASE CALL CUSTOMER SERVICE AT (800) 786-7235, OPTION 1.

Print Birth Mother's Name _____

Kit ID (located on the side of the kit) _____

1 IT IS NOT TOO LATE TO UPGRADE YOUR SERVICES

Cord Blood Premium Service Upgrade - If not already enrolled with the Premium service, I wish to upgrade the cord blood processing technology, to maximize the number of stem cells and deplete the most red blood cells.

Cord Tissue Service Upgrade - (choose vial option)

2 Vials

6 Vials

I wish to add / upgrade cord tissue cryopreservation service to my enrollment. By checking any of the boxes, I agree to the terms and conditions outlined in the Client Agreement and **additional processing & storage fees**. Please call Cryo-Cell International to discuss at (800) 786-7235, option 1

2 BABY'S INFORMATION AS IT SHOULD APPEAR ON THE PRESERVATION CERTIFICATE

Please print legibly in capitals. If the name is not present on this form, it will appear as Cryo-Cell's default name

Baby's First Name:

Sex: M F

Baby's Middle Name:

For multiple babies: Please complete a form for each child.

Baby's Last name:

Complete after delivery. All answers to this questionnaire are strictly confidential.

3 BIRTH MOTHER'S POST-DELIVERY HEALTH HISTORY QUESTIONNAIRE

1 Were you treated for any bacterial infections around the time of delivery? If yes, what for and treatment? _____

YES NO

3 Have you been bitten by an animal suspected of rabies within the last six months preceding delivery? _____

YES NO

2 At the time of birth, was your child treated for any infections or other disorders? If yes, what for and treatment? _____

YES NO

4 At any point during the pregnancy have you had a medical diagnosis of a Zika virus infection? _____

YES NO

4 SINCE COMPLETION OF YOUR HEALTH HISTORY QUESTIONNAIRE - HAS THERE BEEN ANY UPDATES TO THE FOLLOWING QUESTIONS

A At any point during the pregnancy have you lived in or traveled to an area with active Zika virus transmission? (Review the most current list of ZIKA virus areas of transmission <http://www.cdc.gov/zika/geo/index.html>) or call Cryo-Cell International for guidance 800-786-7235 option 1. If yes, list the country, cities, and dates of travel _____

YES NO UPDATE

H Have you had any new medical problems or diagnosis or new medical treatments? _____

YES NO UPDATE

B At any point during the pregnancy have you had sexual contact with a man who, in the 6 months prior to sexual contact, has had a Zika virus infection or lived in or traveled to an area with active Zika virus transmission? If yes, list the country, cities, and dates of travel _____

YES NO UPDATE

I Had sexual contact with a male who has ever had sexual contact with another male? _____

YES NO UPDATE

C Has your sexual partner or a member of your household had a transplant or other medical procedure that involve being exposed to live cells, tissue or organs from an animal? _____

YES NO UPDATE

J Had an accidental needle stick, come into contact with anyone else's blood or had a blood transfusion? _____

YES NO UPDATE

D Taken any of these medications: Growth Hormone from Human Pituitary Glands, Insulin from cows (Bovine, or Beef, Insulin), Hepatitis B Immune Globulin (HBIG) or received an unlicensed vaccine? _____

YES NO UPDATE

K Received money, drugs or other payment for sex? _____

YES NO UPDATE

E Traveled outside the U.S or Canada, including Puerto Rico and the Caribbean? Note: if you reside outside of the US or Canada, check NO. For each visit list the country, cities, and dates of travel: _____

YES NO UPDATE

L Have you been in Juvenile detention, lockup, jail, or prison for more than 72 hours? _____

YES NO UPDATE

F Been diagnosed with West Nile, Malaria, Chagas, babesiosis, or Hepatitis? Treated for syphilis or other sexually transmitted infections? _____

YES NO UPDATE

M Used needles to take drugs, steroids, or anything not prescribed by your doctor? _____

YES NO UPDATE

G Had sexual contact with anyone: Who has/suspected of having HIV/AIDS? Has been paid for sex or used needles for anything not prescribed by their doctor? _____

YES NO UPDATE

N Now live with a person or has had sexual contact with someone who has hepatitis? _____

YES NO UPDATE

O Have you gotten a tattoo, ear, or body piercing? Was it performed using sterile non-reusable equipment? YES NO

YES NO UPDATE

P Had any vaccinations or shots or come into contact with anyone who had a smallpox vaccination? If yes, what? _____

YES NO UPDATE

Q Have you or any blood relatives been diagnosed with Creutzfeldt-Jakob Disease (CJD)? Have you been diagnosed with a neurological disease? _____

YES NO UPDATE

5 SIGNATURE

I agree to collection, processing, testing, and storage of my specimens.

Printed First And Last Name _____

Birth Mother's Signature _____

Date _____

Translator/Interpreter - Print First and Last Name (if applicable) Date _____

(Family members shall not serve as interpreters or translators)

CRYO-CELL USE ONLY

Reviewed by: _____ Forward Date: _____

QA Review by: _____ M Z V S va X MD E

Review Date: _____

Comment: _____

MD Review: _____ Review Date: _____

Comment: _____

CLOSED BY: _____ DATE: _____