Client Information

CryoCell INTERNATIONAL

COMPLETE THIS FORM POST DELIVERY AND RETURN WITH LABELED SPECIMENS, IF YOU HAVE ANY QUESTIONS PLEASE CALL CUSTOMER SERVICE AT (800) 786-7235, OPTION 4.

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: | | | | | | | | | | | | | | | | | | |

Baby's Middle Name: | | | | | | | | | | | | | | | | | | |

Baby's Last name: | | | | | | | | | | | | | | | | | | | | | | | | | |

Sex: ☐ M ☐ F

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

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

3 BIRTH MOTHER'S POST-DELIVERY HEALTH HISTORY QUESTIONNAIRE

		YES	NO
1	Were you treated for any bacterial infections aound the time of delivery? If yes, what for and treatment? _____	☐	☐
2	At the time of birth, was your child treated for any infections or other disorders? If yes, what for and treatment? _____	☐	☐
3	Have you been bitten by an animal suspected of rabies within the last six months preceding delivery?	☐	☐
4	At any point during the pregnancy have you had a medical diagnosis of a Zika virus infection?	☐	☐

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

		YES	NO UPDATE
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** _____	☐	☐
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** _____	☐	☐
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?	☐	☐
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**?	☐	☐
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:** _____	☐	☐
F	Been **diagnosed** with West Nile, Malaria, Chagas, babesiosis, or Hepatitis? **Treated** for syphilis or other sexually transmitted infections?	☐	☐
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?	☐	☐
H	Have you had any new medical problems or diagnosis or new medical treatments?	☐	☐
I	Had sexual contact with a male who has ever had sexual contact with another male?	☐	☐
J	Had an accidental needle stick, come into contact with anyone else's blood or had a blood transfusion?	☐	☐
K	Received money, drugs or other payment for sex?	☐	☐
L	Have you been in Juvenile detention, lockup, jail, or prison for more than 72 hours?	☐	☐
M	Used needles to take drugs, steroids, or anything not prescribed by your doctor?	☐	☐
N	Now live with a person or has had sexual contact with someone who has hepatitis?	☐	☐
O	Have you gotten a tattoo, ear, or body piercing? Was it performed using sterile non-reusable equipment? YES ☐ NO ☐	☐	☐
P	Had any vaccinations or shots or come into contact with anyone who had a smallpox vaccination? If yes, what?_____	☐	☐
Q	Have you or any blood relatives been diagnosed with Creutzfeldt-Jakob Disease (CJD)? Have you been diagnosed with a neurological disease?	☐	☐

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: _____