ovobiosurance

Family cord blood stem cell bank

Registration

Documents & informed consent



Health Canada

Registration No: 100184

ACCREDITED

8000, boul. Décarie, Montréal QC H4P 2S4

514 798-2000 ext. 613 | biosurance@cliniqueovo.com | cliniqueovo.com

OVO Biosurance — Registration form

PLEASE COMPLETE THIS SECTION IN CAPITALS

Mother As per health card	First name	Last name	
Date of birth	day-month-year	**Email**	
Health insurance	#	Expiry date	
Occupation		Employer	
Telephone	Home	Office	Cell.
Complete address	Numero, street	City	
	Province	Postal Code	Country

Expected delivery date		**Current pregnancy :**	☐ single pregnancy (one baby) ☐ twin pregnancy
Are you carrying a baby for someone else? If so, the birth mother and biological mother each need to complete a confidential medical questionnaire.			☐ yes ☐ no
Delivery hospital		**Birth at home**	☐ yes ☐ no
Place	City	Province	

Obstetrician/Midwife	Name

Father / Partner As per health insurance card	First name	Last name	
Date of birth	day-month-year	**Email**	
Health insurance	#	Expiry date	
Occupation		Employer	
Telephone	Home	Office	Cell.
Complete address ☐ Same as mother or:	Numero, street	City	
	Province	Postal Code	Country

Other contact (optional)	Name	**Relation**	
Telephone	Home	Office	Cell.
Complete address	Numero, street	City	
	Province	Postal Code	Country

☐ 1st kid ☐ 2nd kid ☐ 3rd kid ☐ 4th kid ☐ 5th kid - enrolled in the stem cell bank

Comments: _____

How did you hear about us? _____

Referred by: _____

Mother's initials: _____ **Father's / Partner initials:** _____

Consent form

I, _____ (mother)

and _____ (father / partner), (hereinafter, “We”)

authorize the collection of umbilical cord blood (hereinafter, the “Umbilical Sample”) from our child (hereinafter, the “Child”) and its transport to OVO Biosurance (hereinafter, the “Bank”) for processing, testing, cryopreservation (freezing) and storage of the recovered hematopoietic stem and progenitor cells (hereinafter, the “Stem Cells”).

I (the mother) understand that it is my responsibility to answer accurately all questions in the medical questionnaire. We understand that the medical questionnaire will be reviewed to determine the Child’s Umbilical Sample’s eligibility for storage and that a positive or incomplete response may restrict its eligibility for storage and/or future use.

We agree to disclose relevant information to the best of our knowledge, identify information that is unknown, and notify the Bank of significant subsequent infectious, genetic or hematologic diagnoses that may affect the Sample. Relevant biological family history may be requested, including in cases involving donor eggs, donor sperm or a gestational carrier.

We understand that this consent permits the collection, processing, and testing of the Child’s Umbilical Sample and the cryopreservation and storage of the Child’s Stem Cells. We understand that the umbilical cord and the umbilical cord blood are usually discarded after the Child’s delivery. We wish to arrange collection and processing of the Child’s Umbilical Sample in order to preserve any Stem Cells contained therein so they may be available as a possible future treatment for disease(s) in the Child, and/or, if eligible, other persons.

We understand that the Child’s own Stem Cells may be unsuitable for certain conditions, including some inherited disorders and leukemia, because they may contain the same genetic abnormality or premalignant cells. Established indications are limited; investigational applications and future cell expansion technologies may never become suitable or available. We have had an opportunity to discuss alternatives, including public donation where available, medically indicated directed donation and choosing not to bank cord blood.

We have received information about the Umbilical Sample collection process. We consent to and will request collection by our health care provider after the Child’s birth using the Bank’s collection kit, where clinically appropriate. Collection is not guaranteed and may be prevented or limited by medical, obstetric or technical circumstances. Maternal and newborn care take priority, and collection must not interfere with emergency care or clinically recommended delayed cord clamping. Delayed clamping may reduce the volume available for banking. Kit return and refund conditions are governed by the written fee schedule provided before signing.

We understand that We are responsible for:

- sending the Child’s Umbilical Sample, together with the birth mother’s blood samples and the required documentation, to the Bank in accordance with its instructions. We understand that the Bank is not responsible for the Child’s Umbilical Sample until it is received at the Bank’s laboratory
- ensuring that the Child’s Umbilical Sample is delivered at the Bank as soon as possible after collection, and never more than twenty-four (24) hours after the birth of the Child. We understand that the efficacy and viability of the Stem Cells may be reduced if the Umbilical Sample arrives at the Bank more than thirty-six (36) hours after the birth of the Child.
- ensuring that the collection kit, both before and after the collection of the Child’s Umbilical Sample, is maintained near room temperature (recommended temperature between 18 and 25 °C). We understand that the efficacy and viability of the Stem Cells may be reduced if the Child’s Umbilical Sample is not maintained at the appropriate temperature prior to its delivery at the Bank.

We understand that the quantity and quality of the Stem Cells extracted from the Child’s Umbilical Sample can only be assessed after the Child’s Umbilical Sample has been processed. We understand that there is no guarantee that the Stem Cells obtained from the Child’s Umbilical Sample, if there are any, will be suitable for storage and/or for future transplantation or for another use. We understand that it is not possible to know if the Child’s Umbilical Sample fulfills the Bank’s storage requirements or if there will be any limitations on its eligibility for use before knowing the results of all the admission tests.

Mother’s initials: _____ **Father’s / Partner initials:** _____

We understand specifically that:

a. contamination of the Child's Umbilical Sample by micro-organisms occurring during the birth, could make the Child's Stem Cells unusable for transplantation or for other medical use;

b. the Child's Umbilical Sample, could contain insufficient numbers of viable Stem Cells for transplantation or for another medical use;

c. there is no guarantee that the Child's Stem Cells will survive the processing, the cryopreservation and/or the thawing process;

d. the success of a transplantation or another medical use of the Child's preserved Stem Cells cannot be guaranteed;

e. if the Child's birth mother suffers from or has suffered from a transmissible disease, it may not be possible to store and/or use the Child's Stem Cells for future transplantation or for another medical use;

f. the Bank retains reference aliquots and/or attached segments, as applicable, for identification, confirmatory testing and quality purposes according to its approved procedures and applicable requirements;

g. the Bank reserves the right to reject any Umbilical Sample in the absence of the provision of the birth mother's blood in the required time period or if the Umbilical Sample is received by the Bank more than 36 hours after the delivery of the Child or if the Umbilical Sample does not meet the current Health Canada regulations;

h. eligibility for future use depends on the relevant maternal, donor and biological family medical history, screening and testing results, product quality and the proposed recipient and use. Acceptance for storage does not establish eligibility for transplantation.

We understand that certain cord blood components, such as red blood cells and plasma remaining in the Child's Umbilical Sample after processing will not be stored in the Bank with the Child's Stem Cells. We consent that the Bank will treat these components according to the regulations in force and may use them for quality control testing or validation of procedures.

We understand that the Bank, following the regulations of Health Canada, may be required to perform supplementary testing on the Child's Umbilical Sample and/or birth mother's blood, limiting the Bank's capacity to continue storage of the Child's Stem Cells.

We understand that for certain procedures involved in stem cell processing and storage, the Bank has to use the services of other medical suppliers to guarantee a complete service for storage of the Child's Stem Cells.

SCREENING OF THE BIRTH MOTHER

The Child's birth mother consents to blood collection and testing for transmissible infections, including HIV, hepatitis B, hepatitis C, syphilis and other agents required by the Bank's approved procedures and applicable requirements. For cord blood donor assessment, specimens are generally collected within seven days before or seven days after cord blood collection; the Bank's instructions specify the applicable timing and tubes. Maternal specimens should accompany the Umbilical Sample whenever possible; otherwise, separate delivery must be arranged with the Bank. Insufficient, missing or improperly timed specimens may prevent completion of the eligibility assessment and restrict storage or future use. A maternal blood aliquot may be retained, if available, for further required testing. Reactive screening results do not necessarily establish a diagnosis and may require confirmation. Negative tests do not eliminate every risk of transmission. Results will be communicated confidentially to the mother and/or an authorized health care professional as appropriate, and reported to public health or other authorities when legally required. Additional maternal or Child testing may be necessary before future clinical use.

CONSIDERATION ABOUT THE CORD BLOOD VOLUME COLLECTED

Presently, the Bank's recommended minimum volume of umbilical cord blood for processing and storage (excluding the quantity required to perform the regulatory testing and the volume of the anticoagulant already present in the collection bag) is 20 mL. However, even if the volume of cord blood is below the recommended volume, the cord blood sample may still be valuable, in certain cases, for young children. Furthermore, advances in ex vivo expansion, gene therapy and cell research may enable the future use of stem cells derived from smaller volumes of umbilical cord blood. These investigational advances do not guarantee that a low-volume Sample will become clinically useful.

We understand that volume alone does not establish clinical usefulness; viable cell count, contamination, product quality and the intended recipient also matter. Please select one of the processing options below. If instructions are missing or inconsistent, the Bank will attempt to contact us and follow its documented interim handling procedure. A missing choice does not authorize research.

Mother's initials: _____ **Father's / Partner initials:** _____

☐ We authorize processing and storage even if the volume is below 20 mL, provided that the Bank considers processing appropriate. We accept the applicable processing and storage fees and understand the limitations of a low-volume unit.

☐ If the cord blood volume is less than 20 mL, We do not authorize processing or storage. We authorize disposition according to the choice below. Destruction is permanent and irreversible. We remain responsible for the registration, collection kit and applicable transportation charges disclosed in the signed fee schedule.

If We have chosen not to process our cord blood sample when the volume is less than 20 mL, and the actual volume of our sample is less than 20 mL, We consent for our sample to be:

☐ Used by the Bank for an approved research project.

☐ Destroyed in accordance with the Bank's approved procedures.

Signature of mother	Signature of father/partner

COSTS

We understand that We are responsible for the costs of the birth mother's blood collection and testing, and also the processing, cryopreservation and storage of the Child's Stem Cells. The payment plan option for the first year will be made when the cord blood collection kit is issued. In the eventuality where it is not possible to process the Child's Stem Cells, the Bank agrees to reimburse the costs paid proportionally to the work that has already been performed.

Standard payment plan

The initial fee, which includes the first year of storage, is payable to the Bank upon delivery of the collection kit. Please refer to the fees published on the Bank's website for current pricing.

- The fee of $400.00 plus applicable taxes is non-refundable in the event of collection and non-processing of the Child's Sample (e.g. low volume).
- A fee of $400.00 plus applicable taxes applies if the collection kit is not used.
- In the event of an emergency registration, a fee of $200.00 plus applicable taxes applies and includes delivery of the collection kit to the hospital.

Financing program

A financing program is available. Please contact the Bank for details on the terms and conditions.

Storage fees for subsequent years

The costs for the annual storage of the Child's Stem Cells are subject to change. The annual storage cost is due and payable at the beginning of each subsequent storage period. 10- or 20-year packages with applicable discounts can also be purchased. We also understand that the annual storage costs are not reimbursable and that no proportional adjustments will be made for partial years of storage. The maximum duration for storage of the Child's Stem Cells will be governed by the laws in force in the province of Quebec and by the regulations of Health Canada.

Mother's initials: _____ **Father's / Partner initials:** _____

We understand that, according to the chosen payment plan, an invoice covering the storage costs of the cryopreserved Child's Stem Cells for the subsequent year will be sent to us thirty (30) days before the anniversary of the cryopreservation date, by regular mail at the last address We provided to the Bank. We understand and accept that the complete payment of this invoice is due within the thirty (30) days following receipt of the invoice. In case of non-payment, a second invoice will be sent 30 days later. Finally, if no response is received, a registered letter will be sent to the same address thirty (30) days after the second invoice. If payment remains outstanding ninety (90) days after the registered letter was mailed, this agreement will be considered terminated, and We authorize the Bank to use the Sample for research or destroy it in accordance with its approved protocols and applicable law. For unpaid invoices, the Bank reserves the right to add administrative costs. A lawsuit could also be filed against you for all invoices that remain unpaid without further notice or delay. We must also point out to you that it would then be your responsibility to pay any additional costs that this procedure would entail. Any administrative or collection charges must be disclosed and legally permitted.

CONTACT DETAILS

We authorize contact for matters necessary to provide the service. Sensitive information will be communicated using appropriate safeguards.

We understand and agree to provide the Bank with our current address and a valid telephone number for as long as the Bank is storing the Child's Stem Cells, and We agree to update this information as appropriate. We understand and agree that it is our responsibility to inform the Bank of any changes in our names, address or telephone numbers. The Bank reserves the right to communicate with the birth mother at any time.

DISTRIBUTION, TRANSFER, DONATION AND/OR DESTRUCTION OF THE STEM CELLS

We understand and agree that:

- release, transfer, donation or destruction requires valid written authorization from the person or persons legally entitled to make that decision. The Bank may request evidence of authority.
- as the Child acquires legal capacity, the Bank will review who may receive information and provide instructions under applicable Québec law and obtain updated consent where required. If the Child dies or becomes incapable, the legally authorized decision maker will be determined under applicable law.
- if instructions conflict or legal authority is uncertain, the Bank may suspend a non-urgent irreversible action while clarification or appropriate legal direction is obtained. Any allocation of legal costs remains subject to applicable law.
- in the case that transplantation and/or another use of the Child's Stem Cells is medically prescribed, the frozen stored Child's Stem Cells will be transferred by the Bank to the designated medical facility only after the Bank receives a copy of the " Consent to send a frozen cord blood sample to a health care facility: FO-BSC-008" duly signed by all signatories of the present consent or by a person entitled with parental authority or by the Child's legal guardian and after any outstanding processing or storage costs have been paid in full. In the case of the Child's Stem Cells being used for transplantation or another medical use, the Bank is responsible for the medical and administrative preparation of the Child's Stem Cell shipment to the designated medical facility and any storage fees already paid will be refunded proportionally for the storage period. Release also requires identity verification, the treating facility's acceptance and completion of applicable donor and product assessments. Urgent clinical requests will be promptly escalated to the Bank's designated medical authority.
- in order to transfer the Stem Cells to another storage facility, the Bank must receive a copy of the "Consent to transfer cord blood samples stored at OVO Biosurance to another cord blood bank: FO-BSC-012" duly signed by all signatories of the present consent or by a person entitled with parental authority or by the Child's legal guardian. This consent would have to be signed at least a month before the intended transfer date. If We decide to transfer the Child's Stem Cells to another storage facility, We are responsible for all the arrangements regarding the transfer and that the only responsibility of the Bank is to prepare the Stem Cells for transfer. We accept any financial responsibility resulting from the transfer of the Child's Stem Cells along with the risks associated with the transfer of the Child's Stem Cells and that all the outstanding costs due to the Bank need to be paid before any transfer of the Child's Stem Cells.
- if the Bank ceases operations We will have the opportunity to transfer the Child's Stem Cells to another storage facility. The Bank will follow its documented continuity plan, provide notice where practicable, and explain the receiving facility, transfer arrangements and applicable costs.

Mother's initials: _____ **Father's / Partner initials:** _____

- the Bank reserves the right to relocate its business place and/or its operations even though the Bank does not currently plan relocation.
- the future use of the Child's Stem Cells by a person other than the Child may require further screening tests and/or additional blood tests from the birth mother of the Child and/or from the Child and will be subject to the legislation in force at the moment of proposed usage.
- HLA typing assesses tissue compatibility but does not, by itself, establish donor eligibility, guarantee compatibility or make the Stem Cells immediately eligible for use by another person. The timing and extent of HLA typing depend on the intended use and applicable requirements. Additional or confirmatory testing may be required before release. Optional HLA typing, if selected, will be performed on a suitable specimen according to the Bank's procedures. The stated charge is $750.00 plus applicable taxes, subject to confirmation against the current fee schedule. Refund conditions must be disclosed before acceptance.

☐ We wish to proceed with the supplementary testing (HLA typing), and We will pay the associated supplementary fee of $750.00+tax.

☐ We do not wish to proceed with the supplementary testing (HLA typing), and We understand that if the Stem Cells are requested for use by a relative of the Child further testing may be required in accordance with the regulations in place at the moment of proposed usage.

Signature of mother	Signature of father/partner

TERMINATION OF STORAGE

We understand We may decide at any moment to terminate the storage of the Child's Stem Cells. We will be able to terminate this agreement by providing the Bank with a copy of the "Consent to discontinue storage of frozen cord blood sample: FO-BSC-007" duly signed by all signatories of the present consent or by a person entitled with parental authority or by the Child's legal guardian.

We understand that in the event that We would like to terminate the storage of the Child's Stem Cells or in the case of nonpayment (expiry of this agreement), We can still have control of the fate of the Child's Stem Cells sample by completing the options concerning their disposition detailed within consent FO-BSC-007.

If this agreement is terminated because payment remains outstanding ninety (90) days after the registered letter was mailed, the Sample will be handled in accordance with the research-use or destruction authorization set out above. For termination for other reasons, the Bank will request written disposition instructions and follow its approved procedures and applicable law.

We confirm and accept that if We decide to cease the storage of the Child's Stem Cells, We will not be reimbursed for any portion of the storage fees already paid.

In the event the Bank determines the Child's Stem Cells to be ineligible for storage, it will notify us and request written instructions regarding the disposition of the Child's Stem Cells. If We fail to provide written instructions within 90 days of receiving notification of its ineligibility for storage, the Bank may discard the sample.

RESPONSIBILITY LIMITATION

We understand that natural disasters, accidents, equipment failure and other events may cause deterioration or loss of the Stem Cells despite appropriate safeguards. The Bank remains subject to its legal and professional obligations; the occurrence of such an event does not automatically release it from liability.

We understand that it is possible that the collection device and/or the storage system may fail with the consequence of the loss of the Child's Stem Cells.

We understand that if the Bank is unable to process and/or store our umbilical cord sample, due to circumstances beyond their control, arrangements are in place to transfer the sample to another cord blood bank for processing and/or storage.

Mother's initials: _____ **Father's / Partner initials:** _____

The Bank will provide its services with the care required by applicable law and its professional obligations. Nothing in this consent excludes or limits liability where prohibited by Québec law, including liability for bodily or moral injury, or material injury caused by intentional or gross fault. Any additional limitation must be clearly stated in the service agreement and legally enforceable.

APPLICABLE LAW

This agreement is governed by the laws applicable in Québec and applicable federal laws of Canada. Disputes are subject to the jurisdiction of the competent courts without limiting mandatory legal rights.

CONFIDENTIALITY

We understand that all information contained in our file remains confidential as determined by the law and that We have the right to access this information. Only authorized staff of the Bank will have access to this file and these staff are bound by a confidentiality agreement. All files are kept in a contained safe area to ensure confidentiality.

Personal and health information will be accessed and disclosed only as necessary to provide the authorized services, with valid consent or another lawful basis. Necessary disclosures may include authorized laboratories, service providers, receiving medical facilities, regulators and public health authorities. Appropriate confidentiality safeguards will apply. We may request access to or correction of our own information, subject to applicable law and the Child's and other persons' rights.

Information generated during processing may be used for quality activities necessary to provide the service, with appropriate safeguards. Optional research use requires separate valid consent or another lawful authorization. Declining optional research will not affect the contracted banking service.

Privacy contact: privacy@cliniqueovo.com

INFORMED CONSENT

The mother's consent to her blood collection and testing is personal to her. Questions about authority to consent for the Child will be resolved under applicable law. An interpreter or additional explanation will be provided where needed.

We give this consent voluntarily, within our respective legal authority. Signing as a partner does not, by itself, confer parental authority. The Bank may request documentation of authority where necessary.

By signing this consent form, We request, authorize and give our consent to the Bank, its physicians, agents, representatives and employees to process, test, separate, cryopreserve and store the Child's Umbilical Sample. We understand that our acceptance and our consent to participate in this program are completely voluntary.

We certify that We understand the risks and the benefits of the collection and the storage of the Umbilical Sample, that We have been informed about the other available treatments, that We have read the information contained within this document, that We understand the content of this document and that We obtained answers to all questions that We had concerning the terms of this consent.

We sign voluntarily and acknowledge that We will receive a copy of this signed consent and the applicable service agreement and fee schedule.

Mother's full name:	**Signature:**	**Date/time:**
Father's/other authorized representative's full name:	**Signature:**	**Date/time:**
Ovo biosurance person obtaining consent (name):	**Signature:**	**Date/time:**

Mother's initials: _____ **Father's / Partner initials:** _____

Maternal Medical History Questionnaire

Last name as per health card		**First name** as per health card	
Date of birth day-month-year			

Please complete this confidential medical history questionnaire accurately and return the original to OVO BioAssurance. You will be asked to update this information at the time of delivery. Depending on your medical history and subsequent infectious disease test results, additional testing may be required to determine your eligibility for the cord blood storage program. If you are unsure about any aspect of your medical history, please consult your physician and ask them to review this questionnaire before returning it to us.

If you answer "Yes" to any question, please provide details in the section at the end of this questionnaire.

QUESTIONS			Yes	No
1		Are you suffering now from any illnesses including bacterial, viral or fungal infection?	☐	☐
2		In the past 2 years, have you seen a physician or been hospitalized for any medical condition or had a surgery? **(provide dates, name of medical establishment, name of physician and the reason)**	☐	☐
3		Have you had any complications in this pregnancy or a previous pregnancy?	☐	☐
4		For the actual pregnancy, did you undergo any of the following procedures to get pregnant:		
	a)	In vitro fertilization (IVF)?	☐	☐
	b)	sperm donor and/or egg donor? If so, which one: _____	☐	☐
	c)	surrogate mother?	☐	☐
5	a)	Have you ever tested positive for syphilis?	☐	☐
	b)	Have you ever tested positive for HTLV-1/2?	☐	☐
6		Have you ever tested positive for HIV (AIDS), Hepatitis B or Hepatitis C?	☐	☐
7		Are you a person who may be at risk for HIV (AIDS), hepatitis B or hepatitis C? (please indicate if you belong to one of these categories)		
	a.	person who reports nonmedical intravenous, intramuscular, or subcutaneous injection of drugs in the preceding three months	☐	☐
	b.	person with hemophilia or related clotting disorder who has received human derived clotting factor concentrates	☐	☐
	c.	person who has engaged in sex in exchange for money or drugs in the preceding 3 months	☐	☐
	d.	person who has had sex with a person known or suspected to have HIV, hepatitis B or hepatitis C	☐	☐
	e.	person with a history of non-medical intranasal drug use within the previous 3 months	☐	☐
	f.	person who has had sexual contact within the previous 3 months with individuals described in items a to e, or with people whom they know or suspect to be infected with HIV or with clinically active hepatitis B or hepatitis C.	☐	☐
	g.	person who has had a new sexual partner and has engaged in anal sex within the previous 3 months.	☐	☐

Last name:		First name:	

QUESTIONS			Yes	No
	h.	person who has had more than one sexual partner and has engaged in anal sex within the previous 3 months.	☐	☐
	i.	person who, in the preceding 3 months, has been exposed to blood, body fluids or a needle infected or suspected to be infected with HIV, hepatitis B or hepatitis C, through percutaneous inoculation or through contact with an open wound, non-intact skin, or mucous membrane	☐	☐
8		Have you ever been in a correctional facility, juvenile detention center, prison, psychiatric institution or jail for more than 72 consecutive hours during the previous 3 months?	☐	☐
9		Have you had any tattoo, acupuncture, ear or body piercing in the past 3 months, using unsterilized equipment (use of contaminated instruments or ink, instruments not sterilized between uses, etc.)?	☐	☐
10		Based on your family history, occupation, lifestyle, do you consider yourself to be at risk for HIV or Hepatitis B or C?	☐	☐
11		In the last 3 months, have you been in close contact with anyone with clinically active viral hepatitis? (e.g. living in the same household, where sharing of the kitchen and bathroom facilities occurs regularly)	☐	☐
12		In the past 3 months, have you taken any oral medications (by mouth) to prevent HIV infection	☐	☐
13		Within the past 2 years, have you received injectable medication(s) to prevent HIV infection	☐	☐
14	a)	Have you ever been diagnosed with Creutzfeldt-Jakob disease (CJD) or variant CJD?	☐	☐
	b)	Have you ever been diagnosed with Gerstmann-Sträussler-Scheinker syndrome or any other prion disease (transmissible spongiform encephalopathy)?	☐	☐
15		Have you ever been diagnosed with the following diseases: malaria, babesiosis, Chagas disease, Leishmaniasis, West Nile Virus, Lyme disease, or any blood borne parasitic disease?	☐	☐
16		Have you ever been diagnosed with a brain tumor or a neurological disease such as dementia, Alzheimer, Parkinson's, subacute sclerosing panencephalitis (SSPE), progressive multifocal leukoencephalopathy, amyotrophic lateral sclerosis (ALS) or an infection such as encephalitis or meningitis of viral, bacterial or unknown etiology?	☐	☐
17		Have you ever been diagnosed with tuberculosis (TB) or SARS or exposed to TB or SARS?	☐	☐
18		Have you recently exhibited unexplained weakness, fatigue, nausea, diarrhea, weight loss, swollen lymph glands, persistent fever or cough, night sweats or purple spots on the skin?	☐	☐
19		Have you ever been diagnosed with rabies or within the past 6 months, been bitten by an animal and treated as if the animal was rabid?	☐	☐
20		Have you ever been diagnosed with blood or bleeding disorder?	☐	☐
21		Have you ever received human-derived pituitary growth hormone or Dura mater? If so when and in which country did you receive it?	☐	☐
22		In the past 12 months, have you received a blood transfusion or any blood components, bone marrow or clotting factors for hemophilia or had a tissue or organ transplant?	☐	☐
23		Have you ever been refused as blood, bone marrow, organ donor or to store your baby's umbilical cord blood?	☐	☐
24		Do you currently take or have taken in the past 2 years, any prescribed medications other that vitamins, mineral supplements or Diclectin? **If yes, please list all medications used and the reasons for their use.**	☐	☐

Last name:		First name:	

QUESTIONS		Yes	No
25	Have you been vaccinated against hepatitis B in the last 5 years?	☐	☐
26	Have you ever received the vaccinia vaccine (against smallpox)?	☐	☐
27	Have you had any vaccinations in the past 3 months? If yes, please provides which ones and when.	☐	☐
28	Have you ever been investigated or diagnosed for any heart, lung, liver, kidney, bone, bowel or any other chronic disease? Is so, which one(s)? (if hospitalization was required provide dates, medical institution)	☐	☐
29	Have you ever been diagnosed with an immunological or hematological disorder?	☐	☐
30	In the last 12 months, have you been diagnosed or treated for syphilis, gonorrhea, genital herpes, Chlamydia, trichomonas or any other sexually transmitted disease?	☐	☐
31	Have you ever been diagnosed or investigated for any autoimmune or chronic degenerative disease? (E.g. lupus, rheumatoid arthritis, multiple sclerosis, myasthenia gravis, polyarteritis nodosa or sarcoidosis).	☐	☐
32	In the past 3 years, have you traveled or lived outside of Canada? **(please provide dates and countries visited)**	☐	☐
33	Have you ever been treated for a travel-related illness after returning home from travel?	☐	☐
34	Have you ever lived, traveled or received medical treatment in Africa?	☐	☐
35	Have you spent a total of three or more months in Europe since January 1980?	☐	☐
36	Have you received a blood transfusion or treatment with blood product in Europe since January 1980?	☐	☐
37	Have you been diagnosed with Zika virus infection at any point in your pregnancy or had sexual relations at any time in your pregnancy with a male who is known to have had a medical diagnosis of Zika virus infection within six months prior to the sexual contact or who has resided in, or travelled to an area with active Zika virus transmission within the past three months?	☐	☐
38	Have you ever been diagnosed with a genetic disease? (if yes, specify in the explanations)	☐	☐
39	Have you ever taken insulin for a diabetes? (specify the date and type of insulin)	☐	☐
40	Have you ever been diagnosed with cancer of the breast, ovary, uterus, liver, bowel, blood (e.g., leukemia), lymph glands (e.g., lymphoma), skin (e.g., melanoma) or any other type of cancer?	☐	☐
41	Are you (the mother) or the father of the newborn adopted? If yes, please indicate whether you have access to the medical and genetic history of the biological parents.	☐	☐
42	For each of the following questions, has anyone in the newborn family (genetic mother, genetic father, brothers and sisters **of the newborn**) ever been: If the response is yes, please give details of the illness and the person affected.		
	a. been affected or is affected with a neurological disease, a prion-related disease, an active encephalitis or meningitis?	☐	☐
	b. diagnosed with rabies or within the past 6 months, been bitten by an animal and treated as if the animal was rabid?	☐	☐
	c. infected with HIV, active hepatitis B, hepatitis C, HTLV, syphilis or West Nile virus?	☐	☐
	d. diagnosed with breast, ovarian, uterine, prostate, liver, or bowel cancer or a cancer of the blood or lymph glands?	☐	☐
	e. diagnosed with a hereditary genetic disorder affecting the blood or the immune system?	☐	☐

Last name:		First name:	

QUESTIONS		Yes	No
	f. received human-derived pituitary growth hormone or Dura mater? If so when and in which country.	☐	☐
	g. diagnosed with a malignant disease?	☐	☐
	h. identified as having a hereditary predisposition to cancer?	☐	☐
	i. diagnosed with an inherited genetic disorder, such as a severe red blood cell disorder, white blood cell disorder, immune deficiency/dysregulation disorder, platelet disorder, or a metabolic/storage disease (e.g., Tay-Sachs disease or Hurler syndrome)?	☐	☐
43	Has anyone in the newborn's family has been affected or is affected with Creutzfeldt-Jakob disease (mad cow disease)?	☐	☐

Last name:		First name:	

Please indicate the question number and provide an explanation for each “Yes” answer.
Attach an additional sheet if necessary.

#	DETAILS

INFORMED CONSENT FOR THE MEDICAL QUESTIONNAIRE

The safety of blood and blood components is of paramount importance. Please be aware that eligibility to use the cord blood depends, among other factors, on medical history and blood test results. Use of this cord blood by anyone other than the original donor (your child) may require additional testing, including further blood collection from the birth mother or donor. Any use must also comply with Health Canada regulations in effect at the time of use.

If you have any questions or require further clarification, please contact us.

I certify that I have read all the statements above and have answered all questions truthfully and to the best of my knowledge.

Mother’s signature	**Date: day-month-year**