



Cord Blood Donor Short Screening Form

MATERNAL INFORMATION

Baby's Mother's Full Name (Please Print)		Today's Date	Baby's Mother's Birth Date		
Previous/Other Name(s) Used (e.g., Maiden Name, Nickname)				Baby's Mother's Email Address	
Mailing Address	Apt.#	City	State	Zip Code	
Primary Phone	Secondary Phone	Signature of Person Completing this Form and Relationship to Baby's Mother			
If interpreter used, add name and phone number here		Language Spoken	Dialect		

BABY'S RACE AND ETHNICITY INFORMATION

Baby's Ethnicity: Response is required, please check one.		<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
Baby's Race: Of which group(s) is your baby a member? (Select all that apply)			
American Indian or Alaska Native <input type="checkbox"/> Alaska Native or Aleut <input type="checkbox"/> North American Indian <input type="checkbox"/> American Indian South or Central American <input type="checkbox"/> Caribbean Indian	Black or African American <input type="checkbox"/> African <input type="checkbox"/> African American <input type="checkbox"/> Black Caribbean <input type="checkbox"/> Black South or Central American	Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino (Philippino) <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> South Asian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Southeast Asian	
Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander	White <input type="checkbox"/> Eastern European <input type="checkbox"/> Mediterranean <input type="checkbox"/> Middle Eastern <input type="checkbox"/> North Coast of Africa <input type="checkbox"/> North American <input type="checkbox"/> Northern European <input type="checkbox"/> Western European <input type="checkbox"/> White Caribbean <input type="checkbox"/> White South or Central American <input type="checkbox"/> Other White		

Have you (Baby's Mother) ever been told not to donate blood or cord blood? <i>If yes, please explain why and when.</i>	YES	NO
In the past 12 months, did you (Baby's Mother) receive a transfusion of blood from someone other than yourself?	YES	NO
In the past 12 months, did you (Baby's Mother) receive a tattoo or piercing? <i>If YES, were shared or non-sterile inks, needles, instruments or procedures used for the tattoo or piercing? YES/NO</i>	YES	NO
In the past 12 months, have you (Baby's Mother) participated in any activity that may pose a risk for the transmission of communicable diseases? (for example: IV drug use, sex in exchange for money) <i>If yes, please explain.</i>	YES	NO
Do you, or any immediate family members (Baby's Mother, Baby's Father, or Baby's Sibling(s)) have any significant medical history issues (cancer, immune disorders, blood cell disorders, hepatitis virus or other serious illnesses)? <i>If yes, please check which <u>immediate family member(s)</u> and list what illness(es).</i> <input type="checkbox"/> Baby's Mother _____ <input type="checkbox"/> Baby's Father _____ <input type="checkbox"/> Baby's Sibling _____	YES	NO
Have you had a medical diagnosis of ZIKA infection at any point during your pregnancy? OR Resided in, or traveled to, an area with active ZIKA transmission at any point during your pregnancy?	YES	NO

Estimated Delivery Date: _____

Anticipated Delivery Facility: _____

OB Provider: _____