Bloodworks

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. ☐ Hispanic or Latino ☐ 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
- ☐ Alaska Native or Aleut
- ☐ North American Indian
- ☐ American Indian South or Central American
- ☐ Caribbean Indian

Black or African American
- ☐ African
- ☐ African American
- ☐ Black Caribbean
- ☐ Black South or Central American

Asian
- ☐ Chinese
- ☐ Filipino (Pilipino)
- ☐ Japanese
- ☐ Korean
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Southeast Asian

Native Hawaiian or Other Pacific Islander
- ☐ Guamanian
- ☐ Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ North Coast of Africa
- ☐ North American
- ☐ Northern European
- ☐ Western European
- ☐ White Caribbean
- ☐ White South or Central American
- ☐ Other White

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, 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) ***If yes, please explain.***	**YES**	**NO**
Do you (Baby's Mother), Baby's Father, or Baby's Sibling(s) have any serious or life-threating diseases (cancer, immune disorders, blood cell disorders, genetic diseases, or viral hepatitis)? ***If yes, please check which <u>immediate</u> family member(s) and list what illness(es).*** ☐ Baby's Mother _____ ☐ Baby's Father _____ ☐ Baby's Sibling _____	**YES**	**NO**
At any time during your pregnancy, have you (Baby's Mother) had a medical diagnosis of ZIKA virus infection?	**YES**	**NO**
At any time during your pregnancy, have you (Baby's Mother) resided in or traveled to a risk area for the ZIKA virus? ***(Zika risk areas include India, Mexico, France, Bahamas, Philippines, and Thailand. For a complete country list and map of areas with Zika risk see https://www.cdc.gov/zika/areasatrisk.html).***	**YES**	**NO**

Estimated Delivery Date: _____ Anticipated Delivery Facility: _____

OB Provider: _____