



Jeevan Public Cord Blood Bank

(Unit of Jeevan Blood Bank and Research Centre)



22, Wheatcrofts Road, Nungambakkam, Chennai 600 034
 Mobile : 97908 97918 / 89399 99214 • Email : stemcell@jeevan.org • Website: www.jeevan.org

Licence Number : TN002

ENROLLMENT FORM

Hospital Record No:

ALL FIELDS ARE MANDATORY. PLEASE FILL IN CAPITAL LETTERS.

Your Family

Your Name :

Date of Birth : / /

Mother tongue : State of origin:

Occupation :

Husband's Name:

Date of Birth : / /

Mother tongue : State of origin:

Occupation :

About Your Children

No.	Name	Age	Date of Birth
1.			
2.			
3.			

Address for Communication :

..... Pin code:

Mob No.: Land Line No:

Email ID (In capital letters) :

This Pregnancy

Expected date of delivery (EDD): / /

Is this pregnancy normal ? Yes No

Number of babies: Single Twins

Doctor and Hospital

Your Doctor's Name :

Hospital Name :

Address :

Tel/Mob No.:

Email ID (In capital letters)

How did you hear about Jeevan Stem Cell Bank?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Your Doctor | <input type="checkbox"/> News Paper |
| <input type="checkbox"/> Ultrasound clinic / Laboratory | <input type="checkbox"/> Website |
| <input type="checkbox"/> Childbirth class | <input type="checkbox"/> Magazine |
| <input type="checkbox"/> Another Donor | <input type="checkbox"/> Radio / T.V |
| <input type="checkbox"/> Friend | |

Others:

FAMILY HISTORY QUESTIONNAIRE

Please read carefully and answer the following questions by a (TICK) mark in the box provided.

If your answer is 'Yes', please provide details.

- | | | | |
|---|----------------------------------|------------------------------|-----------------------------|
| 1. Details of this pregnancy | <input type="checkbox"/> Natural | <input type="checkbox"/> IVF | |
| 2. Is this your first pregnancy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 3. Have you ever had any abnormal test result during an earlier pregnancy? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are all your previously born children alive and healthy? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Has any one in your close family suffered from cancer / blood disorders / any other illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 6. Have any of your family members had any surgery before the age 30 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 7. Are you and your husband related prior to marriage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 8. Are either of you adopted ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

MATERNAL HEALTH HISTORY QUESTIONNAIRE

Please read carefully and answer the following questions by a (TICK) mark in the box provided.

If your answer is 'Yes', please provide details.

1. In the past 12 months have you:

1.1. Did you see the doctor for any illness? Yes No

1.2. Have you had a blood transfusion during this pregnancy? Yes No

1.3. Have you ever been rejected as a blood donor? Yes No

1.4. Have you had any dental procedure? Yes No

1.5. Have you accidentally been exposed to someone else's blood or body fluids? Yes No

1.6. Have you had any surgery in the last 12 months? Yes No

1.7. Have you had any needle injury including ear or body piercing or tattoo? Yes No

1.8. Have you been treated for rabies or been bitten / scratched by any animal? Yes No

1.9. In the past 12 months have you had sexual contact with: Yes No

a) A person who has jaundice?

b) Anyone who has a bleeding disorder?

c) Anyone who has ever used needles to take drugs, steroids, or anything **not prescribed by their doctor**?

d) Anyone who has HIV/AIDS or had a **positive** test for HIV/AIDS?

2. Have you ever used any drugs of abuse ? Yes No

3. In the last 12 weeks what vaccinations have you had ? T.T. Hepatitis B Others

4. Has your HIV/AIDS test ever been **Positive**? Yes No

5. Have you had any blood disorder or bleeding problem?
Have you ever been given any injections to treat the bleeding problem? Yes No

6. Have you ever had TB (Tuberculosis)? If yes, when were you treated ? Yes No

7. Have you had any type of cancer? – Kindly specify if ‘yes’ Yes No
8. During your pregnancy, have you had a medical diagnosis of Zika virus infection? Yes No
9. During your pregnancy, have you resided in or travelled to a risk area* for the Zika virus? Yes No
10. During your pregnancy, have you had sexual contact with a male who
- Was diagnosed with a Zika virus infection in the 6 months prior to the sexual contact? Yes No
 - Traveled to or resided in a risk area* for the Zika virus in the 6 months prior to the sexual contact? Yes No

Risk Areas* • The Caribbean • Central America • South America • Pacific Islands • Mexico

Informed Consent:

1. **I was provided with the document “Information to Cord blood Donors” and I have read and understood the contents of the same and consent to donate cord blood.**
2. I understand that if found fit for processing, the cord blood will be tested for transfusion transmissible infections including Hepatitis B, Hepatitis C and Human Immunodeficiency Virus.
3. I understand that the cord blood will also be HLA (Human Leukocyte antigen) typed for matching purposes.
4. I understand that the donated cord blood will be used for treating diseases approved by Government of India.
5. **I understand that the collected cord blood may not be processed or tested, if it does not pass acceptance criteria and will be discarded.**
6. **We understand that by donating our baby’s cord blood, we and our child do not have any further rights to the same. However, Jeevan Stem Cell Bank, will make all efforts to provide a suitable unit, subject to availability, if there is a requirement by any member of the family (the child, parents and siblings) that donated the cord blood. We agree to pay the prevailing processing, testing and shipping costs, in such an event.**

Your signature

Husband’s signature

Date

.....

For review by **Jeevan Stem Cell Bank**

Signature of Interviewer & Date

Comments & Signature of Reviewer & Date