

SLCBB ID

NMDP ID

Disposition _____ -63 = _____
 Total Weight _____ Cord Blood Volume _____ Tech/Date: _____

Mother's Name: _____ Mother's birthdate _____ Estimated Due Date: _____

Mailing Address of Mother of Baby: _____

Identity of the above donor confirmed by verifying two identifiers (name, birthdate) Yes _____
 Nurse's signature _____

Labor and delivery data completed by: _____

LABOR AND DELIVERY DATA

Hospital: _____ Delivering Physician: _____ Date/Time of Delivery: _____

Labor: Yes No Length of Labor: _____ hours Was Labor Induced: Yes No Augmented

Route of Delivery: Vaginal Assisted Vaginal Delivery?: Forceps Meconium Staining: Yes No
 Vacuum Fetal Distress: Yes No
 C-section Scheduled Non-Scheduled Reason for C-section: _____

Duration of Rupture of Membranes: _____ hours (____ min.) **DELAYED CORD CLAMPING:** Yes No **If Yes, how long?** _____
 (Seconds)

Were any abnormal or remarkable findings that were detected during the **mother's** physical assessment and chart review: Yes No
 If yes, please describe: _____

Maternal Temperature During Labor (>100°F or 37.7°C?): Yes No **IF YES, WHAT WAS THE HIGHEST TEMP:** _____

Number of Infants Delivered: _____ **NOTE: Cord blood collections are for singleton births only.** G _____ P _____ Ab _____

Medications given during Labor and Delivery: Anesthesia: Yes No
 List other medications: _____

Was mother tested for Group B Beta strep: Yes No **If Yes, result:** Negative Positive
 If yes, list medication used during labor _____

List Complications During Delivery: _____

Was any blood or blood component given to mother during labor/prior to delivery? Yes No (If yes, the collection should not take place)

Mother's Pre-Natal Blood Test Results

HBsAg Negative Positive Test Date: _____ Mo. _____ Day _____ Year _____ No Record
 Syphilis Negative Positive Test Date: _____ Mo. _____ Day _____ Year _____ No Record
 Anti-HIV Negative Positive Test Date: _____ Mo. _____ Day _____ Year _____ No Record
 Mother's ABO Blood Group: _____ Rh Type: _____

FOR SLCBB USE

INFANT DATA

Sex: Male Female Birth Weight: _____ grams 5 minute Apgar: _____ Gestational Age (by MD): _____
 (weeks)

Infant Temp (>100°F)? Yes No **IF YES, TEMP** _____ Infant Race _____

Evidence of Infection or chorioamnionitis? Yes No

Evidence of any infant congenital anomaly? Yes No Comments: _____

PLEASE BE CERTAIN THE FOLLOWING ITEMS ARE ENCLOSED IN THE COLLECTION BOX:
 CORD BLOOD COMPLETED PAPERWORK
 Cord Blood Collection Bag Consent Form
 Labor and Delivery Data Sheet Med History Questionnaire (if not sent in)

SLCBB
 NURSE REVIEW/DATE _____

GUIDELINES FOR ASSESSMENT OF MOTHER AND BABY

Physical assessment of the mother of the baby is obtained by the physician and/or the labor and delivery nurse. This should include a review of the records in the prenatal chart as well as a physical assessment at the time of presentation to the hospital. Any abnormal or remarkable findings should be documented on the labor and delivery data form. FDA recommends screening for signs that may indicate high-risk behavior for, or infection with a relevant communicable disease. Some of the following are not physical evidence of HIV, hepatitis, syphilis, or vaccinia infection, but rather are indications of high-risk behavior associated with these diseases.

THE CORD BLOOD COLLECTION SHOULD NOT TAKE PLACE IF ANY OF THE FOLLOWING ARE NOTED:

MATERNAL CHART REVIEW

Multiple births

Known positive serology for: HIV, Hep B or C, HTLV-I/II, syphilis, or gonorrhea

Active sexually transmitted disease at the time of delivery

Maternal high-risk behavior (IV drug use, taking money or drugs for sex, etc)

Mother or Father of baby with history of cancer or blood disorder requiring chemotherapy

Mother of Baby with History of an autoimmune disorder (such as lupus, MS, Crohn's disease, rheumatoid arthritis, or other immunologic disorder) *classified as severe.*

Blood transfusion during the 12 months prior to delivery or during labor and delivery

Unexplained weight loss, night sweats, temp > 100.5°F for more than 10 days, cough, persistent diarrhea

Gestational age < 34 weeks

MATERNAL PHYSICAL EXAM

Physical evidence of STD's such as genital ulcerative disease, herpes simplex, syphilis, chancroid

Physical evidence of active illicit drug use such as needle tracks, examination of tattoos which may be covering needle tracks, etc

Physical evidence of **recent** tattooing, ear or body piercing (using shared or non-sterile instruments or inks)

Lymphadenopathy

Oral thrush, white spots or unusual blemishes in the mouth

Blue spots or purple spots consistent with Kaposi's sarcoma

Unexplained jaundice, hepatomegaly or icterus

Physical evidence of sepsis, such as unexplained generalized rash

Large scab, rash, or necrotic lesion consistent with recent immunizations

Generalized vesicular rash

Maternal temperature greater than 102° F or 39.0° C

Malodorous placenta or amniotic fluid, or suspicion of chorioamnionitis

Excessive maternal bleeding

Placental trauma or expulsion of placenta before or during collection

PLEASE DOCUMENT IF ANY OF THE FOLLOWING WERE IDENTIFIED ON THE PHYSICAL EXAM OF THE INFANT

Evidence of any infant congenital anomaly should include screening for fetal malformations which include metabolic disorder, chromosomal abnormalities or structural anomalies. Specifically this should include notations of the following

Absent digits on hands or feet

Absent radii

Extra digits on hands or feet

Horseshoe kidney

Microcephaly

> 6 café au lait spots

Dwarfism

Albinism

Hemi-hypertrophy

Please also note if the baby had any signs or symptoms of possible sepsis or congenital infection:

elevated temp, petechial rash, hepatosplenomegaly, thrombocytopenia (Blueberry muffin syndrome)

Also note the presence of a 2 vessel cord