



Maternal ID Label

Questionnaire for umbilical cord blood donation

You have read the information on umbilical cord blood donation and would like to become a cord blood donor. Please answer the questions in this questionnaire.

Who are the questions for?

The questions are intended for the **mother** of the child (baby). Where information about the child's father, siblings (brothers and sisters) or other relatives is required, it will be specifically mentioned.

How should you answer the questions?

For each question, check the answer that is most appropriate for you.

For some questions we would like additional information from you. Please write your answer in the additional space next to the questions.

Important: Please answer truthfully.

Only in this way can you protect yourself and a possible recipient of the umbilical cord blood.

There is space in section C at the end of the questionnaire. You can provide additional information here.

If you have any questions or concerns, please contact your midwife or physician. They will be pleased to help.

Please only complete the questionnaire earliest **4 weeks** before the expected date of birth. This ensures that the content is up to date.

A. Information about the mother

| | |
|-----------------------------|--|
| Surname | |
| First name | |
| Date of birth | |
| Street, house number | |
| Postcode, Place | |
| Telephone | |
| E-mail | |



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B. Health-related questions

1. Background information on the family and pregnancy

- a) How did you become pregnant: did you receive donor eggs or donor sperm? Or are you a surrogate mother? Yes No

- b) Are you familiar with the medical history of your child's biological father? Yes No

- c) Are you and the child's biological father related? Yes No

If so, how are you related?

2. Your health in the last 4 weeks

Were you ill in the last 4 weeks? Or did you have a temperature above 38.5°C? Yes No

If yes, please describe the illness or symptoms.

.....

3. Medication during pregnancy

a) Have you taken medication during your pregnancy, e.g. tablets, injections, suppositories? Yes No

If yes, please specify the medication.

.....

b) Have you taken Neotigason® / Soriatane® in the last 3 years? This is a medication used to treat psoriasis. Yes No

4. Immunotherapy and vaccinations

a) Have you ever received immunotherapy? This includes e.g. serum or medications derived from humans or animals. Yes No

If so, please specify the immunotherapy?

.....

b) Have you been vaccinated in the last 4 weeks? Yes No

If yes, which vaccination did you receive?

- Flu RSV Pertussis (whooping cough)
- Covid-19 Tetanus Rabies
- Other vaccination:

Please write the date of the vaccination here:



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5. Do you have or have you had any of the following illnesses or symptoms?

If so, please specify e.g. the precise illness, time, treatment, stating whether resolved or still present.

a) High blood pressure before or during pregnancy e.g. arterial hypertension, pre-eclampsia, HELLP syndrome Yes No

Your information:

b) Cardiovascular disease Yes No

Your information:

c) Respiratory disease Yes No

Your information:

d) Stomach or intestinal disease Yes No

Your information:

e) Kidney, bladder, urinary tract or genital tract disease Yes No

Your information:

f) Neurological disease e.g. epilepsy, meningitis Yes No

Your information:

g) Immune system disease e.g. allergy, chronic inflammatory disease such as Morbus Crohn or an autoimmune disease Yes No

Ihre Informationen:

h) Infectious disease Yes No

Your information:

i) Are/were you in contact with a person with a contagious or infectious disease? Yes No

Which disease does the person have?

When did the contact take place?

j) Blood disease Yes No

Your information:

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5. Do you have or have you had any of the following illnesses or symptoms? - continuation -

k) Cancer Yes No

Your information:

l) Diabetes Yes No

- Type I Type II Gestational
 MODY «Adult-onset diabetes type II of the young»

m) Thyroid disease Yes No

- Hashimoto's thyroiditis Graves' disease
 Other disease:

Which treatment did you receive?

From when to when did the treatment take place?

n) Other diseases not mentioned above Yes No

Your information:

6. Accident, surgery, blood transfusion

a) In the last 12 months have you had: Yes No

- an accident an operation

If so, please provide more information:

b) Have you ever received a blood transfusion? Yes No
 e.g. packed red cells, platelet concentrate, plasma

If so, when?

Why?

In which country?

7. Creutzfeldt-Jakob disease or risk of CJD

a) Do you or does a blood relative have Creutzfeldt-Jakob disease? Yes No
 Or is there a suspicion that you or your relative may have the disease?

If so, who?

- Child's mother Child's father

Other relative:



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7. **Creutzfeldt-Jakob disease or risk of CJD** - continuation -

b) Have you ever had a human tissue transplant? Yes No
 If so, please specify:

.....

c) Have you ever had an animal tissue transplant? Yes No
 If so, please specify:

.....

d) Have you ever had brain or spinal cord surgery? Yes No
 If so, please specify:

.....

8. **Tropical virus or risk thereof (including Chikungunya, Dengue and Zika virus)**

a) Have you been abroad for more than 2 days (48 hours) in the last 6 months? Yes No
 If yes, where were you?

Country:

Region or Town/City:

When did you return?

b) Were you ill during your stay abroad (e.g. fever)? Yes No
 Or have you had symptoms since returning?
 If so, which?

.....

c) During your pregnancy were you ever diagnosed with Chikungunya, West Nile or Dengue infection? Yes No

d) Have you or your sexual partner been diagnosed with Zika infection in the last 4 months? Yes No

9. **Malaria or risk of malaria**

a) Have you ever had malaria? Yes No
 If so, when?



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9. **Malaria or risk of malaria** - continuation -

b) Have you visited a malaria risk area in the last 3 years? Yes No

If so, where?

Country:

Region or Town/City:

c) Have you visited a malaria risk area in the last 4 months? Yes No

If so, where?

Country:

Region or Town/City:

When were you there?

10. **Chagas disease or risk of Chagas disease**

a) Have you ever had Chagas disease? It is an infectious disease. Yes No

b) Were you born or did you grow up outside Europe?
 Or did you live outside Europe for more than 6 months? Yes No

In which country?

When did you live there?

c) Was your biological mother (child's grandmother) born or raised in Central or
 South America? Yes No
 Or did she live there for more than 6 months?

In which country?

When did your mother live there?

11. **Infectious diseases or the risk of infection**

a) Have you ever had one of these diseases? Yes No

Tuberculosis Lyme disease Brucellosis Osteomyelitis

Q fever Toxoplasmosis Babesiosis Leishmaniasis

If so, when?

b) Does anyone you are in close contact with have active tuberculosis?
 e.g. a person you are caring for or a member of the same household Yes No



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12. Jaundice und hepatitis

a) Have you ever had jaundice apart from newborn jaundice? Yes No
 If so, please provide more information.

.....

b) Have you ever had hepatitis? Yes No
 If so, which form? Hepatitis A B C E

c) Has your life, sexual or cohabiting partner had hepatitis in the last 12 months? Yes No
 If so, which form? Hepatitis A B C E

d) Has your life, sexual or cohabiting partner had jaundice (hepatitis with a different cause) in the last 12 months? Yes No
 If so, please provide more information.

.....

13. Risk of HIV and stays in countries with high HIV infection rates

a) Have you been abroad for at least 6 months within the last 12 months? Yes No
 If so, where?

Country:

When were you there?

b) Is it possible you may have been infected with HIV?
 e.g. through sexual contact, medical or paramedical procedures such as
 blood transfusion, tattooing or piercing Yes No

14. Invasive treatments and exposure to human blood

a) In the last 2 months, have you had: Yes No
 A tattoo Piercing Permanent make-up/microblading
 Acupuncture Gastroscopy/colonoscopy

If yes, when?
 If yes, were sterile instruments used? Yes No



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14. Invasive treatments and exposure to human blood - continuation -

- b) In the last 2 months, have you had contact with another person's blood? Yes No
 via needle stick injury or splatter in the eye, mouth or other

If so, when?

15. Have you been in one of the following risk situations?

- a) Change in sexual partner in the last 4 months Yes No
- b) Sex in exchange for money, drugs or medicaments in the last 12 months Yes No
- c) Sex with a partner who had had sex with men in the previous 12 months Yes No
- d) Intravenous drug use in the last 12 months Yes No
- e) Positive test for HIV, syphilis or hepatitis C Yes No

16. In the last 12 months, have you had sexual contact with any partner

- a) who has been exposed to any of the risks listed in question 15? Yes No
- b) who received a blood transfusion? Yes No
- If yes, in which country was the transfusion performed?
- c) who incurred any other HIV risk (e.g. through sex, tattooing or piercing, medical procedures) in a country with a high HIV rate? Yes No

If so, which country was the person in?

17. Details of sexually transmitted diseases and treatment

In the last 12 months have you had symptoms of, or been treated for, chlamydia, genital herpes, syphilis, or any other sexually transmitted disease? Yes No

If so, please specify the disease and the treatment.

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18. Do any of the following diseases run in your family?

*We are only concerned with the father and siblings of your child (no other relatives).
 If so, please indicate who has or had the disease.*

a) Red blood cell disease e.g. thalassaemia, sickle cell anaemia Yes No

Which disease?
Who has the disease? Child's father Child's sibling

b) Aplastic anaemia Yes No

Who has the disease? Child's father Child's sibling

c) Platelet disease e.g. immune thrombocytopenia purpura Yes No

Which disease?
Who has the disease? Child's father Child's sibling

d) Genetic bleeding disorder
 e.g. haemophilia, von Willebrand disease, factor V Leiden mutation Yes No

Which disease?
Who has the disease? Child's father Child's sibling

e) Metabolic and lysosomal storage disease
 e.g. cystic fibrosis, Tay-Sachs, Fabry's disease, Gaucher's disease,
 Niemann-Pick disease Yes No

Which disease?
Who has the disease? Child's father Child's sibling

f) Diabetes Type I Yes No

Who has the disease? Child's father Child's sibling

Diabetes Type II

Who has the disease? Child's father Child's sibling

MODY «Adult-onset diabetes type II of the young»

Who has the disease? Child's father Child's sibling

g) Congenital or acquired immunodeficiency Yes No

Which disease?
Who has the disease? Child's father Child's sibling



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18. Do any of the following diseases run in your family? - continuation -

h) Malignant blood disease Yes No
 e.g. leukaemia, multiple myeloma, myelodysplastic syndrome, essential thrombocythaemia

Which disease?
 Who has the disease? Child's father Child's sibling

i) Cancer Yes No

What type of cancer?
 Who has the disease? Child's father Child's sibling

j) Other diseases Yes No

Which disease?
 Who has the disease? Child's father Child's sibling

C. Is there any other information you would like to provide?

.....

D. Declaration by the mother

**I hereby confirm that my personal details are correct.
 I further certify that I have answered all questions truthfully.**

Surname:

First name:

Date of birth:

Date: Signature of mother:



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Questionnaire review by qualified staff

E. Questionnaire review at time of RECRUITMENT

Comments on Section B "Medical Questionnaire"

Question:

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Question:

.....

Question:

.....

Question:

.....

Questionnaire reviewed at recruitment: Date: Initials

Maternity unit (*please check*):

- Aarau Basel Bern Geneva Ticino

Page 12 is to be completed by qualified personnel at the time of birth.



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F. Questionnaire review at BIRTH

1. The following questions are to be re-addressed to the expectant mother at time of delivery to cover the period between completion of the questionnaire and the delivery.

a) Diseases or changes in health (question 2) Yes No

Your information:

b) Changes to medication and vaccinations (questions 3, 4b) Yes No

Your information:

c) Changes to stays abroad (question 8a) Yes No

Your information:

d) Changes in behavior towards infection risks (questions 14, 15, 16) Yes No

Your information:

2. Health status of mother and child (sub partu exclusion criteria)

a) HELLP syndrome Yes No

b) Signs of infection with fever above 38.5°C in the mother (e.g. suspected intra-amniotic infection) Yes No

c) Malformations, congenital diseases, infectious diseases or signs of infection in the newborn Yes No

Your information:

d) Birth <37+0 week of pregnancy Yes No

e) Multiple pregnancy Yes No

G. CONFIRMATION OF DONOR ELIGIBILITY by the physician

Having reviewed the expectant mother's medical questionnaire and medical history, I hereby certify that there is currently no physical evidence of present or past HIGH RISK BEHAVIOR for communicable infectious disease (HIV, HTLV, hepatitis B or C, sexual communicable disease). Based on the documentation and medical history available to me, I confirm that this donor is able to donate her baby's umbilical cord blood at birth. Should fresh health information emerge that could impact this donation, I undertake to forward it to the umbilical cord blood bank.

Physician

Surname, first name:

Date: Physician's signature: