CORD BLOOD COLLECTION FORM

DESIGNATION REQUEST FORM

FOR FAMILY USE ONLY

Please complete this form and forward to:

National Children's Leukemia Foundation
7316 Avenue U, Brooklyn, NY 11234
718-251-1222 1-800-GIVEHOPE Fax:718-251-1444

(Please print all information)

Expected Due Date: ____________________

Mother's Name: ____ SS# ____________________________________

Address: ____

City: ______________________ State: ______________ Zip: __________ Phone: __________________________

Date of Birth: ________________ Age: _______ Race: ______________ Fax: ______________________________

Family member to contact if you cannot be reached: Name: _____________________ Phone _____________

NEWBORN INFORMATION: (must be filled in within 30 days of birth)

Name: __________________________ Date of Birth: _______ Sex: Male Female

Medical Status: ____

Hospital Chief of Obstetrics: ______________________ Phone: ______________ Fax: ________________

HEALTH CARE INFORMATION:

Hospital Name: ________________________ Hospital Address: _____________________________ Phone: ___________

Attending Physician: __________________________________ Phone: ____________ Fax: ____________

Address: ____

Comments: ____

INSURANCE

Insurance Carrier: ____________________________ Subscriber Name ___________________________________

Address: ____

ID# ________________________________ Group # ____

I understand that the cord blood collected at time of delivery will be processed and stored long term. I understand that NCLF has no obligation whatsoever if the cells are infected or damaged. (A test will be made before use). NCLF does not guarantee success of any future use of the cells. I waive any dispute with NCLF.

Mother's Signature: **X** ___________________________

(Requests must be signed)