

QUESTIONNAIRE

(the data contained herein is subject to medical confidentiality
and used for the purpose of qualifying the child's mother for the collection of cord blood)

*The questions contained in the Questionnaire have been prepared based on, among others, the Regulation of the
Minister of Health of 9th October 2008 concerning the
requirements for quality assurance systems in tissue and cell banks.*

Name and surname of the mother:

Polish Resident ID No. of the child's mother:

Contract No. (filled in by the employee):

FILLED IN BY THE MOTHER:

Choose the answer to your current and best knowledge by placing an "X" next to the answer of your choosing.

QUESTION	YES	NO	I DON'T KNOW
1. Are you currently healthy? If NO, then what is the problem:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you taking any medicines for chronic diseases? If YES, then what medicines:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any anti-infectives (anti-biotics, anti-fungals, anti-virals)? If YES, then what medicines:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had any of the listed diseases? (if YES, please provide results of relevant tests)	YES	NO	I DON'T KNOW
a) tuberculosis (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) viral Hepatitis (when and what type?).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) toxoplasmosis (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) syphilis (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) genital herpes (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been diagnosed with HPV (human papilloma virus)? (if YES, please provide results of relevant tests)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you or any of your relatives (siblings, parents, grandparents) been diagnosed with a genetically determined disease? If YES, who, when and what disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the Child's Father or any of his relatives (siblings, parents, grandparents) ever been diagnosed with a genetically determined disease? If YES, who, when and what disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the Child's siblings ever been diagnosed with a genetically determined disease/ cancer or a disease of unknown aetiology in the medical history? (If any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you or the Child's Father ever been diagnosed with cancer? If YES, who, when and what type:.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you or the Child's Father ever been diagnosed with a disease of unknown aetiology in the medical history? If YES, then when and what where the symptoms of the disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Have you or the Child's Father ever been diagnosed with progressive dementia or degenerative neurological disease, including of unknown origin? If YES, then what disease and when was it diagnosed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
QUESTION	YES	NO	I DON'T KNOW
12. Have you ever been a recipient of hormones obtained from a human pituitary gland (e.g. growth hormone)? If YES, then what hormones and when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been a recipient of a transplant of cornea, sclera, dura mater, or have you ever been subject to an undocumented neurosurgical procedure which could have involved the use of dura mater? If YES, then what and when was transplanted:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had an auto-immune disease? If YES, then what disease and when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been treated with the use of immunosuppressants? If YES, then for what disease and when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. During pregnancy, have you been exposed to substances such as cyanide, lead, mercury? If YES, then when were you exposed and to what substance:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever donated blood at a blood donor centre? If YES, then when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever been disqualified as a blood donor? If YES, then for what reason:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Has any of the viruses listed below ever been detected in your organism? (if YES, please provide results of relevant tests)	YES	NO	I DON'T KNOW
a) CMV – cytomegalovirus (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) HAV – Hepatitis A virus (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) HBV – Hepatitis B virus (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) HCV – Hepatitis C virus (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) HIV – human immunodeficiency virus (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) HTLV – human T-cell leukemia virus (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) EBV – Epstein-Barr virus (when?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you, the Child's Father or your parents come from or have been for a period of over six months in areas with high prevalence of HTLV-1 and HTLV-2 (human T-cell leukemia), i.e.: Japan, Central Africa, the Caribbean, south-east US states, north-east part of South America, Taiwan, Papua New Guinea? If YES, then who, where and for how long:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Over the last 12 months, have you or the Child's Father been to areas with high prevalence of Ebola haemorrhagic fever, i.e. Central Africa or West Africa? If YES, then who, where and for how long:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Over the last 7 weeks, have you been to the Netherlands, in provinces with an increase of Q fever cases (Utrecht, Limburg, Gerderland, Noord Brabant)? If YES, then where and when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had Q fever (also known as query fever)? If YES, then when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Over the last 28 days prior to giving birth, have you been to Andalusia, in particular in the regions with detected cases of encephalitis and meningitis caused by the West Nile Virus (WNV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Have you ever had the West Nile Fever? (caused by the West Nile Virus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you been diagnosed with Zika virus infection? If YES, then when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
QUESTION	YES	NO	I DON'T KNOW
27. Over the last 12 months, have you or the Child's Father been outside the territory of Poland? If YES, then where and when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Over the last 6 months, have you been in close contact (including sexual contact) with:	YES	NO	I DON'T KNOW
a) a person ill with Hepatitis A, B or C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) a person ill with AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) an HIV carrier?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) a person maintaining high-risk sexual relations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) a person who has been diagnosed with Zika virus infection over the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) a person who over the last 6 months has travelled to or stayed in areas threatened by Zika virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Over the last 12 months, have you had (if YES, then when?):	YES	NO	I CAN'T REMEMBER
a) a surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) an endoscopic procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) tooth extraction or other dental procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) transfusion of blood, blood components or immunoglobulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) ear piercing or piercing of other body parts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) a tattoo, acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) other procedure connected with contact with blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
QUESTION	YES	NO	I DON'T KNOW
30. Has any of your relatives been diagnosed with Creutzfeldt-Jakob disease? If YES, then who and when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you been vaccinated against viral hepatitis? If YES, then when was the last vaccine administered:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Have You ever had infection COVID-19? If YES, then when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Over the last 21 days, have you had contact with person ill with Covid -19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. I give consent to having cord blood.

YES NO

35. I give consent to the performance of necessary tests during the processing of blood allowing an assessment of its quantitative and qualitative parameters necessary for making a decision concerning the justifiability of storage.

YES NO

Date

Mother's signature

Thank you for filling in the questionnaire 😊



Filled in by the Supervising Physician of Bank Komórek Macierzystych nOvum:

I. Recommendations concerning the performance of additional serology tests.

A) Based on the data contained in the questionnaire, I recommend that the child's mother should undergo the following additional serology tests:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

The results of the tests are to be sent (delivered) to BKM Novum in person, sent in the form of a scan by e-mail, or by post.

Date:..... Signature and seal of the Referring Physician of BKM Novum

B) **The child's mother has been informed about the recommendation to carry out tests and to deliver their results to BKM Novum by phone and by e-mail / by mail (delete as appropriate)**

Date:.....
Name, surname and signature of the employee of BKM Novum office informing about the performance of tests

II. Qualification/ disqualification* of the child's mother for the collection of cord blood.

Based on the data contained in the questionnaire, I **qualify the child's mother for the collection of cord blood of her child/ children at BKM Novum.**

NOTES:.....

Date:..... Signature and seal of the Referring Physician of BKM Novum

Based on the data contained in the questionnaire, I **declare that the Mother's state of health may have an adverse effect on the quality and therapeutic usability of her child's/ children's cord blood collected at BKM Novum.** I declare that the Child's Mother/ Father was informed about the above in a phone call on and that he/ she upheld her/ his decision to collect and store cord at BKM Novum. An appropriate written declaration will be delivered by the Mother/ Father within days to BKM Novum.

NOTES:.....

Date:..... Signature and seal of the Referring Physician of BKM Novum

Based on the data contained in the questionnaire, I **declare that the Mother's state of health may have an adverse effect on the quality and therapeutic usability of her child's/ children's cord blood collected at BKM Novum.** I declare that the Child's Mother/ Father was informed of the above during a phone call on and he/ she resigned from the collection and storage of cord blood at BKM Novum. An appropriate written declaration will be delivered by the Mother/ Father within days to BKM Novum.

NOTES:.....

Date:..... Signature and seal of the Referring Physician of BKM Novum

Based on the data contained in the questionnaire, I **disqualify the child's mother from the collection of cord blood.** I declare that the Child's Mother/ Father was informed about the above in a phone call on and that he/ she resigned from the collection and storage of cord blood at BKM Novum. An appropriate written declaration will be delivered by the Mother/ Father within days to BKM Novum.

NOTES:.....

Date:..... Signature and seal of the Referring Physician of BKM Novum