

Bloodworks NW
CORD BLOOD PROGRAM

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| <i>For Bloodworks Use Only</i> |
| HPC, Cord Blood Local DIN: |

Maternal Samples

MATERNAL INFORMATION *Please place pre-printed hospital label here or fill in:*

Full Name (Last, First, MI or Name): _____

Medical Record Number: _____

Date of Birth (mm-dd-yyyy): _____

MOTHER'S BLOOD SAMPLE TUBES

Hospital Name: _____

Collected By: _____
Collector's signature Collector's printed name

_____ Collection Date (mm-dd-yyyy) Collection Time (Military)

BLOOD PRODUCTS INFORMATION

48 hours **PRIOR TO** sample draw, did the mother receive blood products? *If yes, please indicate* Yes No

| Type of product | Volume |
|-----------------|--------|
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FLUIDS INFORMATION (e.g., LR, normal saline)

In the **one (1)** hour prior to sample draw, the mother received: less than 2000 mL of fluids more than 2000 mL of fluids

I verify the above Blood Product and Fluids information is accurate.

Signature

Date

Printed Name

Title

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| Reviewed By: _____ Date: _____ |