Family Link® Cord Blood Storage Program

NORTON HEALTHCARE

NOTIFICATION OF CORD BLOOD COLLECTION

Expected Due Date___________________

OB/Midwife_______________________________________ **Mother's Name**_____________________________

Birthing Facility__________________________________ **Mother's SS#**______________________________

City/State/Zip _____________________________________ **Mother's DOB**______________________________

Additional Comments:

AUTHORIZATION TO COLLECT CORD BLOOD AND RELEASE FROM LIABILTY

My patient____________________________ has requested that I, or one of the partners in my practice, collect her baby's umbilical cord and placental blood, "cord blood". As the attending physician/midwife, I have reviewed the prenatal physical assessment and testing and agree to collect the cord blood. I or one of the partners in my practice will collect the cord blood from the clamped and cut umbilical cord immediately following delivery. While collection is a relatively simple procedure, complications may occur during delivery, which could preclude the collection of cord blood. My patient, as evidenced by the signature below, agrees that my judgement shall be absolute and final and releases me, my practice, the hospital/birthing center, its Board of Directors and Officers, its medical staff, and its ancillary staff of any and all liabilities surrounding the collection and handling of the cord blood.

Signature of Obstetrician/Midwife

Name of Obstetrician/Midwife

Date

Signature of Mother

Name of Mother

Date

AUTHORIZATION OF THE RELEASE OF MEDICAL RECORDS/INFORMATION

I agree to allow information or copies of my and my newborn's medical record to be provided to the staff of the Family Link Cord Blood Storage Program. I authorize the release of any information or medical record that is related to my pre-natal care, delivery, and postpartum care as well as any information or medical record that is related to my baby's newborn care and pediatrician care. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of any medical records and/or information for the purpose and extent stated above. This authorization will continue until revoked or canceled by me in writing.

Signature of Mother

Name of Mother

Date

This Section To Be Filled Out By Family Link Staff Only

CORD BLOOD HARVEST/WORKUP ORDERS

As the medical director of the Family Link Cord Blood Collection Service, I request that once collected, the cord blood unit and mother's blood draw along with completed paperwork be packaged for transportation to the laboratory listed below for processing and storage.

Transport to:
NORTON HOSPITAL (Downtown)
TRANSFUSION SERVICES-Blood Bank
200 EAST CHESTNUT STREET
LOWER LEVEL, LABORATORY
LOUISVILLE, KY 40202

Contact Person: Family Link Tech On Call
Phone #: (502) 629-7771
Fax #: (502) 629-7798
Digital Beeper #: (502) 421-0800

(CHECK ALL THAT APPLY)
Routine Cryopreservation/Storage/Testing

Additional Modification/Testing, Specify: ___________________________________

____

Donor/Kit #

Unique Product ID #

Signature of Requesting Family Link Physician

William T. Tse, MD, PhD
Printed Name of Requesting Family Link Physician

Date