Bloodworks NW
CORD BLOOD PROGRAM

	For Bloodworks Use Only
	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

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:_____

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