APPENDIX D

EXAMPLES OF FORMS AND LOGS FOR NOTIFICATION
OF INFECTIOUS DISEASE RESULTS
RECORD OF DONOR NOTIFICATION

CONFIDENTIAL

Donor Name _____________________________ Hospital ID ______________________________
Telephone Numbers (h) ____________________ (w) _____________________________________
*Social Security Number ____________________ *Date of Birth ____________________________
Reason for Donor Notification _________________________________________________________

Notification Letters Sent

Date Letter 1 was Mailed ___________________ Date Letter 2 was Mailed ___________________
Restricted Delivery Receipt Returned to Region? Yes __________ No __________
Letter Returned Marked No Forwarding Address? Yes __________ No __________

Telephone Calls To or From Donor

Date/Time of Contact __________/____________ *ID confirmed? Yes __________ No _________
Date/Time of Contact __________/____________ *ID confirmed? Yes __________ No _________
Comments __________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Appointments for Personal Interview Donor Notification

Date/Time of Appointment ________/________
If First Appointment Not Kept or Cancelled: Date/Time of Appointment ________/________
Signed Information Release Form Received? Yes _________ No ________ N/A _________
Test Results Mailed to Donor’s Physician? Yes _________ No ________ N/A _________

*Ask the donor at the beginning of each telephone contact to state this information for identify verification.
INFORMATION RELEASE REQUEST

I authorize insert Cord Blood Bank name here to release the results of my blood test for insert name of blood test here to me and/or to the following doctor or clinic:

Your name (only if you are requesting that your test results be sent to you)

________________________________________________________________________

Your address (only if you are requesting that your test results be sent to you)

________________________________________________________________________

________________________________________________________________________

Doctor’s Name ____________________________________________________________

Name of Facility ____________________________________________________________

Street Address _____________________________________________________________

City, State, Zip Code ________________________________________________________

Donor/Guardian Signature ___________________________________________________

Donor/Guardian Printed Name ________________________________________________

Donor Social Security Number _______________________________________________

Today’s Date ______________________________________________________________

Please return this form to: insert Cord Blood Bank name and address here

________________________________________________________________________

CBB Staff Use Only

Hospital ID Number _________________________________________________________

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AUTHORIZATION FOR RELEASE OF TEST RESULT INFORMATION

I authorize insert Cord Blood Bank name here to release the results of my blood test for **HIV, anti-HTLV-I/II/anti-HTLV-unable to distinguish viral type** to the doctor or blood center listed below and that I donated blood to that facility on or about insert date here.

Doctor’s Name ______________________________________________________________

Name of Facility _____________________________________________________________

Street Address ______________________________________________________________

City, State, Zip Code _________________________________________________________

Donor Signature _____________________________________________________________

Donor Printed Name _________________________________________________________

Donor Social Security Number _________________________________________________

Today’s Date __________________________________________________________________

____________________________________________________________________________

CBB Staff Use Only

Hospital ID Number _____________________________________________________________

Donation Date __________________________________________________________________

** Select appropriate test name.
DONOR COUNSELING WORKSHEET

CONFIDENTIAL

Date of Counseling ________________________________

Hospital ID Number _________________________________________________________________

Place a check mark next to the items that were discussed with the donor:

1. Specific test results requiring notification ___________________________________________

2. Information from the appropriate fact sheet _________________________________________

3. Placental donation that tested positive and was destroyed ____________________________

4. Donor’s name and other identifying information has been added to a confidential list of deferred donors _______________________________________________________________

5. Donor is no longer eligible to donate blood __________________________________________

6. Donor was referred to his/her personal physician for further medical evaluation and followup ________________________________________________________________________________

7. Written materials were provided __________________________________________________

8. Local support resources were discussed (if applicable) _________________________________

9. Donor has/has not donated blood since 1977 ________________________________________

   If yes, list locations and dates to the best of the donor’s recollection ______________________

____________________________________________________________________________

Ask donor to sign an Authorization For Release of Test Result Information Form.

_____________________________ _________________________
Counselor Signature Date
## CORD BLOOD TRANSPLANTATION STUDY
### NOTIFICATION LOG

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<th>Bar Code Label</th>
<th>Type of Letter Mailed</th>
<th>Date Mailed</th>
<th>Comments</th>
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