

**DOCTOR'S CONSENT FORM**

I, Dr \_\_\_\_\_

from \_\_\_\_\_ (address)

Acknowledge that my patient \_\_\_\_\_

has requested Cell Sense to have her baby's umbilical cord blood collected by myself or an attending midwife, and stored cryogenically within the Cell Sense facility at the Sydney Adventist Hospital.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_