

**For staff use only:**

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_ \_ \_ / \_ \_ \_ / \_ \_ \_ \_

Use hospital identification label

**Consultant:**

## Registration of Consent Form

For donation of brain and related bodily fluids  
by the donor himself/herself

Specimen

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**A Patient details**

Name of donor: .....

Thank you for agreeing to consider a brain donation. This form enables you to consent to a brain donation. **Please read it carefully, add your initials where indicated, and sign this document to record your consent.**

**You have the right to change your mind at any time without giving a reason or explanation.** If you wish to change your mind, please contact the Cambridge Brain Bank on 01223 217336.

**B Provision of information**

I confirm that I have had the opportunity to read and understand the attached leaflet ***The donation of brain tissue after death V2 March 2012***, and that I have a copy to keep.  Yes  No  
Initials .....

I confirm that my questions about post mortem brain donation have been answered to my satisfaction and understanding.  Yes  No  
Initials .....

**Creutzfeldt Jakob disease (CJD)**

To your knowledge, have you been notified that you have been at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.  Yes  No

**C Consent to the retention and use of tissue**

Your gift of brain tissue and related fluids will be placed in the custody of the Cambridge Brain Bank, licensed by the Human Tissue Authority with Licence Number 12318. If you agree, your whole brain, a sample of blood and a sample of cerebrospinal fluid will be used for ethically approved medical research, including genetic research. Please indicate whether you consent to this by placing your initials in the appropriate box overleaf.

I consent to the donation of my brain, a sample of blood and cerebrospinal fluid, on my death to the Cambridge Brain Bank, who will have custody of this material for use in *ethically approved research studies (including genetic research) and/or *ethically approved commercial sector research (*please delete as appropriate).	<input type="checkbox"/> Yes <input type="checkbox"/> No Initials .....
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I agree that projects approved by the National Research Ethical Services may have access to my medical records for research purposes, <b>and understand that confidentiality and anonymity will be maintained.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Initials .....
I consent to the retained tissue samples being used for teaching, quality assurance, public health surveillance and clinical audit.	<input type="checkbox"/> Yes <input type="checkbox"/> No Initials .....
I agree that a summary of the findings of a detailed examination of my brain tissue may be provided to *a person in a qualifying relationship, *a nominated individual or *my G.P. (*please delete as appropriate).	<input type="checkbox"/> Yes <input type="checkbox"/> No Initials .....

**D Signatures**

I confirm that in the event of my death I wish to donate my brain, and a sample of blood and cerebrospinal fluid to the Cambridge Brain Bank for use as indicated on this form. I understand that I have the right to change my mind about any of the decisions I have made, at anytime. If you wish to make changes or withdraw your consent **at any time**, please contact the Cambridge Brain Bank on 01223 217336.

**Signed (Donor):** ..... **Date:** .....

**Name (PRINT):** .....

**Address:** .....

**Telephone:** .....

**Signed (Witness):** ..... **Date:** .....

**Name (PRINT):** .....

**Address:** .....

**Telephone:** .....

**Signed (for Tissue Bank):** ..... **Date:** .....

**Name and Job Title (PRINT):** .....

**Contact details:** .....

**Please turn over**

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**E Contact Details**

**Donor's GP**

**Name:** .....

**Address:** .....

**Telephone number:** .....

.....

.....

**Person in qualifying relationship**

**Name:** .....

**Address:** .....

**Relationship to donor:** .....

.....

**Telephone number:** .....

.....

**Nominated Individual** (if applicable)

**Name:** .....

**Address:** .....

**Relationship to donor:** .....

.....

**Telephone number:** .....

.....

**Tissue Bank Contact details**

**Human Research Tissue Bank Manager**

01223 217336

Department of Histopathology  
Box 235, Addenbrooke's Hospital,  
Hills Road, Cambridge CB2 0QQ

**Senior Research Nurse**

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