

**For staff use only:**

Hospital number:

Surname:

First names:

Date of birth:

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

Use hospital identification label

**Consultant:**

## Registration of Intent Form

For donation of brain and related bodily fluids  
by a person in a qualifying relationship

Specimen

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**A Patient details**

Name of donor: ..... Date: .....

Contact details of donor: .....

Telephone: .....

Thank you for agreeing to consider a brain donation from the above named person. This form enables you to register your interest in a brain donation. **Please read it carefully, add your initials where indicated and sign this document to record your wishes.**

**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, has the donor been notified that they were at risk of CJD or variant CJD for public health purposes?  Yes  No  
If yes, please inform your health professional.

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

The 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.

I understand that the Cambridge Brain Bank would have custody of the brain tissue and related fluids given by this donation.  Yes  No

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**D Signatures**

I wish to register intent to donate the brain from the above named person to the Cambridge Brain Bank as indicated on this form. I understand that I have the right to change my mind about any of the decisions I have made, even after I have signed this form. I understand that I will also need to sign a consent form upon the death of the above named person for the donation to proceed.

If you wish to make changes or withdraw your consent **at any time**, please contact the Cambridge Brain Bank on 01223 217336.

**Signed** (Person in a qualifying relationship): ..... Date: .....

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

**Address:** .....

**Telephone:** .....

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

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

**Address:** .....

**Telephone:** .....

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

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

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

**Telephone:** .....

**Please turn over**

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

Use hospital identification label

**E Contact Details**

**Donor's GP**

**Name:** .....

**Address:** .....

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

.....

.....

**Nominated Individual** (if applicable)

**Name:** .....

**Address:** .....

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

.....

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

.....

**Other contacts**

**Name:** .....

**Address:** .....

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

.....

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

.....

**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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