Consent form

For donation of brain, pituitary tissue and cerebrospinal fluid by the donor
A  Patient details

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

Thank you for agreeing to consider brain, pituitary tissue and cerebrospinal fluid (CSF) donation. This form enables you to consent to brain, pituitary tissue and CSF donation. Please read it carefully, ticking the appropriate box, adding your initials where indicated, and sign this document to record your consent.

Your gift of brain, pituitary tissue and CSF will be placed in the custody of the Cambridge Brain Bank, licensed by the Human Tissue Authority Licence Number 12318.

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, pituitary tissue and CSF after death, PIN2630, v4, February 2015* and that I have a copy to keep.

I confirm that my questions about post mortem brain, pituitary tissue and CSF donation have been answered to my satisfaction and understanding.

**Creutzfeldt Jakob disease (CJD)**

To your knowledge, have you been notified that you have been at risk of CJD or variant CJD by a health professional?

Please tick AND initial

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<th>Yes</th>
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Initials ............

C  Consent to the retention and use of tissue

If you agree, your whole brain, pituitary tissue and CSF will be used for approved medical research, including genetic research. Please indicate if you agree with the following statements by ticking the appropriate box and adding your initials below.

I consent to the donation of my brain, pituitary tissue and CSF on my death to the Cambridge Brain Bank, who will have custody of this material for use in scientifically and ethically approved studies (*including genetic research) and/or *ethically approved commercial sector research (*please delete as appropriate).

Please tick AND initial

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Initials ............
I confirm that in the event of my death I wish to donate my brain, pituitary tissue and CSF 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. 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 CBB): .......................................................................................... Date: .................

Name and job title (PRINT): ...........................................................................

Contact details: 

For staff use only:
Hospital number:
Surname:
First names:
Date of birth:
NHS no: _ _ _ / _ _ _ / _ _ _
Use hospital identification label

I agree that approved projects may have access to my medical records for research purposes, and understand that confidentiality and anonymity will be maintained. □ Yes □ No Initials ........

I consent to the retained samples being used for teaching, quality assurance, public health surveillance and clinical audit. □ Yes □ No Initials ........

I agree that a summary of the findings of a detailed examination of my brain and pituitary tissue may be provided to *a Nominated Individual or *Person in a Qualifying Relationship (for definitions see patient information leaflet), or *my GP (*please delete as appropriate). □ Yes □ No Initials ........
Contact details

Donor's GP
Name: .......................................................... Address: ..........................................................
Telephone number: ............................................... ..........................................................

Nominated Individual (if applicable)
Name: .......................................................... Address: ..........................................................
Relationship to donor: .................................. Telephone number: ............................................... ..........................................................

Person in a Qualifying Relationship
Name: .......................................................... Address: ..........................................................
Relationship to donor: .................................. Telephone number: ............................................... ..........................................................

CBB 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
brbank@addenbrookes.nhs.uk
01223 217336 or mobile 07847 808704

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

For staff use only:
Hospital number: ..................................
Surname: ..................................
First names: ..................................
Date of birth: ..................................
NHS no: _ _ _ / _ _ _ / _ _ _
Use hospital identification label

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File: Consent for: Brain, pituitary tissue and CSF donation by donor
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