

Neuropathology Donation Consent Form

Thank you for considering the gift of brain donation. Your interest in helping research and/or education into neurological diseases may help to alleviate or prevent the suffering of future generations. We hope you will feel that donation is a valued contribution to the improved understanding and treatment of neurological diseases.

*Should you or your family wish to read further information on the progress of the research carried out by the Oxford Brain Bank, you can view Newsletters at:
<http://www.ouh.nhs.uk/services/departments/neurosciences/neuropathology/default.aspx>*

This form records your agreement to the use of tissue being used for medical research. We understand that completing a form may be difficult so soon after the death but it is important you understand what you are agreeing to. Please let us know of any questions or concerns you have and we will try to answer them or seek advice and information on your behalf.

This is a consent form allowing research into diseases of the brain and/or spinal cord. If you wish to restrict your consent please specify in Section Two.

First or other names: _____

Second name – Surname: _____

Male or female: _____ Date of birth: _____

NHS Number: _____ Date of death: _____

Place of death: _____ hospital / home / other (please circle)

Section One: Agreement to donation of central nervous system tissue

It is very helpful when both brain and spinal cord are donated.

Please tick 'Yes' to agree and tick 'No' if you disagree with the option.

I consent to the removal and long term preservation of tissue for research as specified in Section Two.

Yes No Brain and Dura

Yes No Spinal cord

Occasionally we do not have the resources to remove spinal cord even when this box is ticked.

Yes No Other tissue (please specify) _____

Section Two: Use of retained tissue

I agree the tissues may be stored and used for:

Yes No 1. Ethically approved research in an NHS or academic setting.

Yes No 2. Ethically approved research in a commercial setting.

Yes No 3. Education/training relating to human health or performance assessment.

Yes No 4. Quality assurance.

Yes No 5. Clinical audit.

Neurological research often involves genetic analysis of tissue

Yes No 6. Genetic (DNA) studies for ethically approved research.

Section Three: Health records

The identity of the individual is not normally known to a researcher but it is often helpful to know more about the medical history of the person who has died. We require your permission to obtain this information should we wish to do so. Names will never be identified in any published results of research. You may also be asked to complete a separate medical questionnaire in addition to this form.

Yes I understand that members of the research team may look at the health records of the deceased (all information will remain confidential).

Tick to confirm

Section Four: After the research

Brain tissue can be preserved for many years. However it is possible that eventually it will be necessary to dispose of the tissue. This will be done in accordance with the law and government guidance in effect at that date.

Yes I understand the hospital may dispose of tissue when it is of no further use.
Tick to confirm

Section Five: Details of person giving consent

To be completed by the health professional involved in supporting the consent process.

Note: *If consent is taken remotely (over the telephone by a health professional), the donation can proceed after this section is completed. The person giving consent is then sent the form requesting a signature and return to Neuropathology.*

Persons giving consent are ranked in the following descending order of importance:

- A) Spouse or partner*
- B) Parent or child*
- C) Brother or sister*
- D) Grandparent or grandchild*
- E) Niece or nephew*
- F) Stepfather or stepmother*
- G) Half-brother or half-sister*
- H) Friend of longstanding*

Name of person giving consent: _____

Relationship to the deceased: _____

Is consent from the person ranking highest in the qualifying relationship?

Yes No

If no please specify why not: _____

Yes No Has the health professional obtained consent over the telephone?

Signature of health professional: _____

Print name : _____ Date: _____ Time: _____

Section Five: Details of person giving consent continued

This section to be completed by the person giving consent

Signature: _____

Print name : _____

Address: _____

Post Code: _____

Telephone No: _____

We hope you feel that your donation is a valued contribution to the future understanding and treatment of neurological diseases.

It is possible to withdraw consent and if you consider this please call our enquiries number below.

Section six: Signature of health professional supporting consent.

This section to be completed by the health professional

Tick to confirm:

Yes I have explained to the person giving consent, the procedures involved.

Yes I have ensured there are no known objections to the removal of central nervous system tissue

Yes The following information leaflets have been provided:

Specify title of leaflets and version if known.

Signature: _____ Print name: _____

Job title: _____

Organisational address: _____

Telephone number and/or bleep: _____

Yes I have discussed this with a neuropathologist.

Name of pathologist: _____