



## CONSENT FORM- LIVING DONOR

Hospital: \_\_\_\_\_

Department: \_\_\_\_\_

Ward: \_\_\_\_\_ Bed: \_\_\_\_\_

### Section A (for patients who wish to donate tissue to Ramaiah Tissue Bank)

I, \_\_\_\_\_ (*Name of patient or Donor*) (hospital IP No. \_\_\_\_\_),  
have consented to donate my (describe part) \_\_\_\_\_ /  
Amputated limb to be used as allograft for tissue banking / research, to the Ramaiah Tissue Bank.

I understand that the hospital and tissue bank authorities will work to the best of their ability to procure and process the limb or its part for allografting.

I also agree to allow the hospital to do the required blood test for AIDS (HIV1, HIV2) and Hepatitis B and C before they accept my donated tissue.

Signature of patient/attendant: \_\_\_\_\_

ID proof: Copy of Aadhar, PAN, Voter ID, DL etc., \_\_\_\_\_

ID number: \_\_\_\_\_

Relationship if attendant: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_



**Section B (to be certified by the Doctor procuring)**

**LIVING DONOR FORM**

Donor Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Hospital Number: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Operation: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Type of Operation: \_\_\_\_\_

Allograft Procured: \_\_\_\_\_

Surgeon Procuring Bone: \_\_\_\_\_

Medical History \_\_\_\_\_

**Specific History:**

	YES	NO
Tuberculosis		
Chest infection (Bronchopneumonia)		
Urinary tract infection		
Bed sores		
Other infection		
Malignancy		
Auto-immune disease (Rheumatoid Arthritis)		
Avascular necrosis		
Renal failure		
On long term steroids		
Hepatitis Jaundice Liver disease		
Drug addiction		
Abnormal sexual behavior		
Others		

Specify : \_\_\_\_\_





**RAMAIAH**

TISSUE BANK

I, Dr. \_\_\_\_\_, who is the surgeon in charge of the patient in hospital; and have procured the above mentioned Allograft, do hereby certify that the above statements are true to the best of my knowledge. I shall notify the Ramaiah Tissue Bank if any subsequent conditions are noted.

Signature and date: \_\_\_\_\_

Name: \_\_\_\_\_

**For use by Ramaiah Tissue Bank only**

Donor Number: \_\_\_\_\_

Primary processing: Adequate / No

Received container in sealed condition: Yes / No

Received by: \_\_\_\_\_ *(Name and signature of Technologist)*

Verified by : \_\_\_\_\_ Date : \_\_\_\_\_