

# PERTH BONE & TISSUE BANK

This form may be faxed to (08) 9386 9344



Addressograph Label

<b>Surgeon:</b>		<b>Date of surgery:</b>
<b>Procedure:</b>		<b>Hospital:</b>
<b>Allograft required:</b>	<b>Quantity / size</b>	<b>Details</b>
Whole femoral head		
Fine milled		
Coarse milled		
Structural graft		
Strut		
Soft tissue		

I, (patient) \_\_\_\_\_

of (address) \_\_\_\_\_

\_\_\_\_\_

hereby consent to receive allograft / consent to allow allograft to be implanted into my child / ward.  
relationship to recipient: \_\_\_\_\_

- I understand that the donors of allograft have been screened for AIDS and Hepatitis using conventional methods and have been shown to be negative.
- I understand that there is an extremely small risk of transmission of infectious organisms such as HIV, Hepatitis B & C, and prions believed to be responsible for diseases such as Creutzfeldt-Jacob Disease (or variant), and that measures have been taken to prevent infection with organisms that have yet to be identified.
- I understand that the risk of the allograft being rejected is very small.
- I understand that there is a very small risk of developing antibodies to blood cells present in the allograft.

**Recipient / Guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Officer Declaration:**

I, (please print) \_\_\_\_\_ confirm that I have discussed this form with the recipient / guardian.

**Medical officer signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Allograft material will be provided only on receipt of signed consent**

CONSENT TO RECEIVE ALLOGRAFT