

PERTH BONE & TISSUE BANK

This form may be faxed to (08) 9386 9344



Addressograph Label

Surgeon:		Date of surgery:
Procedure:		Hospital:
Allograft required:	Quantity / size	Details
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:** _____
MUST be 18 years or over (legal age)

CONSENT MUST BE SIGNED BY PATIENT

Under certain circumstances next of kin may sign with prior approval from PBTB

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