

# PERTH BONE & TISSUE BANK

This form may be faxed to (08) 9386 9344



Addressograph Label

Surgeon: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Procedure: \_\_\_\_\_

Graft Required: \_\_\_\_\_

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

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

Of \_\_\_\_\_

hereby consent to receive NON IRRADIATED allograft / consent to allow NON IRRADIATED allograft to be implanted into my child / ward.

Relationship to recipient: \_\_\_\_\_

- I understand that the donors of allograft have been screened for HIV and Hepatitis using conventional methods and have been shown to be negative.
- I understand that there is an extremely small risk of transmission of tumour cells, and 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 NON-IRRADIATED ALLOGRAFT**