



Tissue Donation Consent Form
For use under the Uniform Anatomical Gift Act

I, _____ (Name of Legal Next-of-Kin/Authorized Person), am authorized as _____ (Relationship) to _____ (Name of Decedent), whose date of birth is ____/____/____, to make an anatomical gift to Mid-America Transplant Services or its designee. I am not aware of any other person authorized to make this decision. I am not aware of any contrary indications by the deceased, or any objections by a member of the same or a prior class or persons authorized to make this gift.

As the Legal Next of Kin/Authorized Person, I hereby grant permission to remove from the body of the decedent, the tissues marked below:

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| YES | NO | NA | | YES | NO | NA |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Whole eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Skin: back, abdomen, legs-front and back |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart for valves/vascular tissue | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cartilage/bone from knee (under 12 years) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone and soft tissue/vascular tissue-upper body | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone and soft tissue/vascular tissue-lower body | | | |

I have been told, understand and agree that unless otherwise specified below, these donations are made without limitation to Mid-America Transplant Services or its designee (whether for profit or not for profit), and may be used for any lawful purpose including transplantation, therapy, scientific study, research, specialized transplant needs, and/or the production of health related products.

Please check below to demonstrate any restriction on the use of the anatomical gift for scientific study:

- _____ Only tissues intended for transplantation that are unsuitable for transplantation may be used for scientific study.
- _____ No tissue may be used for scientific study
- _____ Special requests or limitations: _____

- I understand and agree that this consent authorizes removal of blood and/or tissue samples for examination, test or diagnostic medical procedure necessary to assure medical acceptability of the tissues donated. This includes blood and/or tissue samples taken to test for conditions including, but not limited to, hepatitis and HIV.
- I authorize the release of current and past medical records including autopsy results, if performed, and certificate of death to all organizations responsible for the utilization of the donated tissues, including Mid-America Transplant Services and its designees.
- I understand that another surgical facility may be needed to carry out all or part of the tissue recovery. I hereby give consent to transportation as Mid-America Transplant Services deems appropriate.
- Donated bone and skin are typically sent to Allosource, where the tissue is prepared and distributed to surgeons in our local area and throughout the country as need dictates. Heart valves and vascular tissues are processed for transplantation most often by Cryolife, where they preserve the donated tissues until they are distributed for use by cardiac and vascular surgeons. Eyes are donated and the corneas distributed to ophthalmologists for their planned corneal and scleral transplants.
- The donation of tissues should not interfere with your funeral plans.
- I have had the opportunity to ask questions concerning the donation and recovery of the tissues and my questions have been answered. I have read this document and the accompanying information and understand it. I further understand that my family will not be charged for any of the services pertaining to the evaluation or recovery of donated tissues.

LEGAL NEXT-OF-KIN/AUTHORIZED PERSON:

Signature _____
Print Name _____
Address _____
City/State/Zip _____
Telephone (____) _____
Alternate phone number (____) _____

WITNESS(ES):

Consent for Donation was explained, requested & witnessed by:
Signature: _____ Print: _____
(Hospital Requestor or MTS Representative)
Additional Witness Signature _____
Print Name: _____
Date _____ Time ____: ____ a.m. / p.m.

This consent was obtained by telephone

Completed form should be faxed to (314) 754-1782

If at any time you have questions about the donation, do not hesitate to contact MTS through the Donor Family Priority Line: 1-800-925-3666

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Identification of Authority to Make Anatomical Gift Decision

Applicable state law provides that consent may be given for an anatomical gift by a person other than the decedent (the “legal next of kin” or “authorized person”) and further provides an order of priority for persons close to the decedent to make binding decisions with respect to anatomical gifts. The chart below sets forth the priority order for anatomical gifts made in the states in which Mid-America Transplant Services operates. **The person executing this document should check the box that indicates his or her relationship with the deceased.**

Missouri	Illinois	Arkansas
1 st An agent of the decedent-POA <ul style="list-style-type: none"> Authorized to make health-care decisions on the principal's behalf by a power of attorney for health care; or Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal 	1 st An individual acting as the decedent's agent under a power of attorney for health care	1 st An agent of the decedent-POA <ul style="list-style-type: none"> Authorized to make health-care decisions on the principal's behalf by a power of attorney for health care; or Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal
2 nd Spouse	2 nd The decedent's surrogate decision-maker identified by the attending physician	2 nd Spouse
3 rd Adult children	3 rd Guardian of the decedent's person	3 rd Adult children
4 th Parents	4 th Spouse	4 th Parents
5 th Adult siblings	5 th Adult children	5 th Adult siblings
6 th Adult grandchildren	6 th Either parent	6 th Adult grandchildren
7 th Grandparents	7 th Adult siblings	7 th Grandparents
8 th Person acting as the guardian at the time of death	8 th Adult grandchildren	8 th Adult who exhibited special care and concern for the decedent
9 th Any other public official authorized to dispose of the body	9 th Close friend	9 th Persons who were acting as the guardian at the time of death
	10 th Guardian of the decedent's estate	10 th Any other person having the authority to dispose of the body
	11 th Any other person authorized or under legal obligation to dispose of the body	

Note: Adult means someone who is at least 18 years of age

By executing this document, you are certifying that there is no one with a superior right to grant the request who is reasonably available. If there are one or more persons with a relationship that is of a higher order, please identify such person(s) and explain why he, she or they did not complete this document. Reasons might include, for example, address unknown, cannot be contacted by telephone, etc:
