Femoral Head Donation Consent Form

OFFICE USE

BB NUMBER

Title: *Please circle* Mr, Mrs, Ms, Miss, Dr, *Other* ……..	Surname:
Given Name/s:	Previous Surname:
Address:	
	Post Code:
Date of Birth:	Home Phone:
Work Phone:	Mobile:
Email Address:	

- If you have difficulty completing this consent form or have any questions regarding bone donation, please contact the Donor Liaison Nurse at PlusLife during business hours on **(08) 6144 3500** or email **donor.liaison@pluslife.org.au**
- Answer each question by marking the appropriate box next to each question using **an ink pen**.
- 'YES' answers will not automatically exclude you from donation. **Please provide extra information in the space provided.**
- Some questions are very personal but all care is taken to respect your privacy. Information given is strictly confidential and will not be shared with a third party.

mark YES or NO

1	Have you been diagnosed with cancer and / or received treatment for cancer? If 'yes' please give details:	☐ YES	☐ NO
2	Have you had any skin lesions removed (benign or malignant)? If 'yes' please give details:	☐ YES	☐ NO
3	Females only: In the past 5 years, have you had an abnormal Cervical Screening Test? If 'yes' please give details:	☐ YES	☐ NO
4	Have you lived in or visited England, Scotland, Wales, N. Ireland or Isle of Man for a cumulative/total period of more than 6 months between 1st January 1980 and 31st December 1996? If 'yes' please give details:	☐ YES	☐ NO
5	Have you migrated to Australia or lived outside of Australia? If 'yes' please list country and date:	☐ YES	☐ NO
6	Have you received treatment for a skin condition (which may include Psoriasis, Pemphigus, Vitiligo)? If 'yes' please give details:	☐ YES	☐ NO
7	Have you received treatment for an Autoimmune Disease (which may include Type 1 Diabetes, Rheumatoid Arthritis, Crohns, Ulcerative Colitis)? If 'yes' please give details:	☐ YES	☐ NO
8	Do you have a history of Osteomyelitis, Osteoporosis, Paget's Disease or Ankylosing Spondylitis? If 'yes' please give details:	☐ YES	☐ NO

mark YES or NO

9	Have you taken or are you taking medication (including natural remedies) on a regular basis? If 'yes' please list: …….. …….. ……..	☐ YES	☐ NO
10	Have you had any serious illnesses? If 'yes' please list illness and date: …….. ……..	☐ YES	☐ NO
11	Have you previously been hospitalised or undergone <u>any</u> surgical procedure including day surgery e.g. gastroscopy, colonoscopy? If 'yes' please list reason, date, hospital & doctor: …… …… …… ……	☐ YES	☐ NO
12	Have you received a transplant of human tissue (including bone or dura), animal tissue, organ, cornea, donated sperm/egg or human pituitary derived growth hormone? If 'yes' please list reason, date, hospital and doctor:	☐ YES	☐ NO
13	Have you donated bone in the past? If 'yes' please list date:	☐ YES	☐ NO
14	Have you received a blood transfusion or blood products after <u>1980</u>? If 'yes' please list country received and date:	☐ YES	☐ NO
15	Have you been advised not to donate blood? If 'yes' please list reason:	☐ YES	☐ NO
16	Have you been diagnosed with a neurological condition, brain disease or seizures (e.g. Dementia, Alzheimer's, Meningitis, Multiple Sclerosis, Myasthenia Gravis, Parkinson's Disease)? If 'yes' please give details:	☐ YES	☐ NO
17	Have you been diagnosed with or do you have a family history of Creutzfeldt-Jacob Disease (CJD)? If 'yes' please give details:	☐ YES	☐ NO
18	Have you been diagnosed with a lung condition (which may include Asthma, Tuberculosis)? If 'yes' please give details:	☐ YES	☐ NO
19	In the past <u>12 months</u>, have you taken steroid medication? If 'yes' please list reason & date:	☐ YES	☐ NO
20	In the past <u>12 months</u>, have you been vaccinated/immunised? If 'yes' please list type & date:	☐ YES	☐ NO
21	Within the past <u>12 months</u>, have you travelled within and / or outside of Australia? If 'yes' please identify place and date:	☐ YES	☐ NO

Donor name: _____ **Date of birth:** _____

		mark YES	mark NO
22	Have you had Typhus, Ross River Virus or Q Fever? If 'yes' please list date:	☐ YES	☐ NO
23	In the past 6 months, have you had an unexplained fever, illness with swollen glands or a rash with or without a fever? If 'yes' please give details:	☐ YES	☐ NO
24	Do you have a current infection? 'If 'yes' what is it and are you having treatment?	☐ YES	☐ NO
25	Have you received treatment for chemical or radiation exposure? If 'yes' please give details:	☐ YES	☐ NO
26	In the past 5 years, have you used illicit, non-prescription drugs/inhalants or injected even once, including cosmetic injections not under the supervision or direction of a medical practitioner? If 'yes' please give details:	☐ YES	☐ NO
27	Have you had Hepatitis A/Yellow Jaundice or tested positive for Hepatitis B, Hepatitis C, HIV (AIDS), Syphilis or HTLV? If 'yes' please list type and date:	☐ YES	☐ NO
28	In the past 12 months, have you been in close contact with someone who would answer 'YES' to questions 26 or 27? If 'yes' please give details:	☐ YES	☐ NO
29	In the past 6 months, have you had a tattoo, skin piercing or acupuncture? If 'yes' please list practice name, address and date:	☐ YES	☐ NO
30	In the past 6 months, have you been injured with a used needle (needle stick injury) or had a splash of blood or body fluids to your eyes, nose, mouth or to broken skin?	☐ YES	☐ NO
31	In the past 12 months, have you had a sexually transmitted disease (which may include Genital Herpes, Genital Warts, Chlamydia, Gonorrhoea)?	☐ YES	☐ NO
32	In the past 3 months, have you had sexual activity with a new partner who currently lives or recently lived overseas?	☐ YES	☐ NO
33	In the past 3 months, have you had sexual activity with a male who you think may be bisexual or had male to male sex?	☐ YES	☐ NO
34	In the past 3 months, have you been a sex worker or engaged in sexual activity with a sex worker?	☐ YES	☐ NO
35	In the past 12 months, have you been confined to a prison or detention centre?	☐ YES	☐ NO
36	In the past 3 months, have you engaged in sexual activity with someone who you think would answer 'YES' to questions 33 - 35?	☐ YES	☐ NO
37	In the event that your donation is not suitable for transplant, do you consent for it to be used for research related to the production and implantation of tissue grafts?	☐ YES	☐ NO

Additional information:

_____

_____

_____

_____

_____

To authorise consent, please complete details overleaf.

Giving false or misleading information may incur penalties including fines and/or imprisonment.
If you do not wish to proceed with your donation, you need only decline. No questions will be asked.

Donor name: _____ **Date of birth:** _____

Surgeon:	Hospital:	Surgery Date:	BB No: Office use

GP Name:	
Practice Name:	
Address:	
	Post Code
Telephone No:	**Fax No:**

In making this declaration I understand:

- I am consenting to donate my bone and give permission for my blood to be tested for infections, including Hepatitis and HIV. If it is required, I consent to undergo a repeat blood test 6 months after surgery.
- As scientific knowledge advances, I may be asked to undergo further blood tests.
- My donation is a gift which is intended for surgical implantation.
- I will not receive payment for my donation, nor will any costs be incurred by me.
- I authorise my GP/Specialist, pathology service and hospital medical records department to release any relevant medical history to PlusLife.
- I authorise PlusLife to collect and securely store information concerning this donation, including test results, medical history, reports and copies of medical records.
- I authorise PlusLife to discuss information concerning this donation, including test results, medical history, reports and copies of medical records to other medical professionals as required.

DONOR TO SIGN ON COMPLETION OF FORM

I hereby declare that my consent has been freely given. I have been given sufficient information to understand the donation process and I have answered all questions truthfully.

Donor name: **Signature:** **Date:**

PlusLife office use

RECORD OF DONOR INTERVIEW

I have confirmed the identity of the Donor (by name, date of birth and address) and confirmed that the Donor had answered the questions and signed the form. I have interviewed the Donor and reviewed the information provided by the Donor herein.

Interviewer name: **Signature:** **Date:** **Time:**

TO BE COMPLETED IN HOSPITAL BY DONOR LIAISON NURSE

Donor name: **Signature:** **Date:**

Interviewer name: **Signature:** **Date:** **Time:**

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