

DOCUMENT OF ANATOMICAL GIFT AUTHORIZATION FOR ORGAN AND TISSUE DONATION

I / You, _____ give permission for
 (Name of Authorizing Person)

the donation of anatomical gifts from _____
 (Name of Donor)

to benefit humanity as set forth in this **Document of Anatomical Gift**. This Document is being completed:

- In-person and witnessed Via telephone and recorded
[] Copy of document provided **[] Copy of document to be mailed.**

If recorded, a copy of this conversation is available upon request.

I / You grant permission for the recovery of the following Organs and/or Tissues for purposes of:

Transplantation Yes No Research Yes No Education and Training Yes No:

ORGANS		TISSUES	
Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Corneas	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Liver	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Heart for Valves/Pericardium	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Kidneys	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Blood Vessels (Arteries and Veins)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Intestines	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Pancreas or islet cell	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	BONE AND CONNECTIVE TISSUE OF: (includes ligaments, tendons & supporting structures)	
		Upper Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
		Lower Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
		Lower Extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
		Pelvis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
		Ribs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Other organ or tissue donation requests: <input type="checkbox"/> None or Specify: _____			

I / You grant permission for:

- Any testing, examinations, and procedures that may be necessary to determine the medical eligibility of this gift. This includes, but is not limited to, testing for HIV and Hepatitis, removal of adjacent blood vessels for organ transplantation, collection of inguinal/abdominal lymph nodes and spleen, and the collection of blood and biopsy samples for potential recipient compatibility testing.
- The release of any information, including medical information found within sources to include, but not limited to, hospital records, death certificates, and postmortem examination (autopsy) reports, and information relating to HIV and Hepatitis to determine organ and tissue eligibility. This information may be released to other appropriate agencies.

I / You understand that:

- Expenses related to the evaluation, maintenance, recovery and placement of the organs and tissues will be paid by the recovery organization(s).
- Funeral and burial expenses are not the responsibility of the recovery organization(s).
- The donation process may take several hours to complete, and the release to the funeral home or coroner/medical examiner's office, when applicable, will occur after the recovery process has concluded.

I / You further understand that:

- I / you may, by this document, limit the use of the bones or tissues, including skin, that are donated or types of organizations that recover, process, or distribute the donation.
- Donated bones or tissues, including skin, may have numerous uses, including for reconstructive and cosmetic purposes, and multiple organizations, including nonprofit and for-profit organizations, may recover, process, or distribute the donations. In addition, recovered tissues may be distributed internationally.
- It may be necessary to transport the Donor to another location for the purpose of tissue recovery.
- I / You specify the following limitations on the use of bones or tissues or on the types of organizations that recover, process, or distribute the donation.

None Specific limitations: _____

_____ Initials of Authorizing Person*

I / You have been given:

- The option to receive information about how donated organs and/or tissue were used.
- The opportunity to ask questions about the donation process
- An explanation of donation options in a language that I / you understand.

Having read this Document of Anatomical Gift in its entirety, or having had it read to me, I / you now give this authorization freely without expectation of any compensation:

Print Name of Authorizing person	SIGNATURE - Authorizing Person*	Date / Time Signed
Relationship to Donor		
Street Address	City, State, Zip	Telephone Number
Print Name of Witness	SIGNATURE – Witness*	Date / Time Signed
Print Name of Person completing this form	SIGNATURE - Person completing form	Date / Time Signed
Name of organization retaining taped consent		

*The person completing this form via telephone should initial the space above as appropriate.

The following contact information is provided for use by the authorizing person(s):

- | | | |
|---|---|--|
| <input type="checkbox"/> University of Wisconsin OPO
450 Science Drive, Suite 220
Madison, Wisconsin 53711-9135
Phone: (866) 894-2676 | <input type="checkbox"/> Lions Eye Bank of Wisconsin
2401 American Lane
Madison, WI 53704
Phone: (877) 233-2354 | <input type="checkbox"/> BloodCenter of Wisconsin/
Wisconsin Donor Network - OPO
9000 W. Chester Street, Suite 250
Milwaukee, WI 53214
Phone: (800) 432-5405 |
| <input type="checkbox"/> American Tissue Services Foundation
5940 Seminole Centre Court, Suite #210
Madison, WI 53711
Phone: (866) 497-7878. | <input type="checkbox"/> RTI Donor Services
8120 Forsythia St. Suite 2
Middleton, WI. 53562
Phone: (877) 733-3700 | <input type="checkbox"/> BloodCenter of Wisconsin/
Wisconsin Tissue Bank
9000 W. Chester Street, Suite 250
Milwaukee, WI 53214
Phone: (800) 722-8230 |

Name of Donor

Date of Birth

ID #