LifeNet Health
1864 Concert Drive
Virginia Beach, VA 23453
866-543-3638

Donor Risk Assessment Interview

LifeNet Health of Florida™
3928 Summit Blvd. Ste 29
Pensacola, FL 32503
866-366-6774

Donor Name: [redacted] (First) [redacted] (Middle) [redacted] (Last)

Person Interviewed: [redacted] (Name) parents (Relationship)

Contact Information: [redacted] (Phone) [redacted] (Address) [redacted] (City) [redacted] (State) [redacted] (Zip)

The interview was conducted: By telephone ☐ In person ☒

Person Interviewed: _____ (Name) _____ (Relationship)

Contact Information: (___) _____ (Phone) _____ (Address) _____ (City) _____ (State) _____ (Zip)

The interview was conducted: By telephone ☐ In person ☐

Person conducting interview and completing this form:

[redacted] (Print Name) [redacted] (Signature) PN 3/9/17 C (Date/Time)

I want to advise you of the sensitive and personal nature of some of these questions. They are similar to those asked when someone donates blood. We ask these questions for the health of those who may receive her/his* gift. I will read each question and you will need to answer to the best of your knowledge with a "Yes" or "No."

1. Complete the following questions for donors less than 5 years of age:	☐N/A	**1.** N/A- Donor is greater than 5 years of age
1a. Was the child 18 months of age or younger?	☐No ☐Yes	1a or 1b. If yes to either question, a Donor Risk Assessment Interview **must be completed** for the biological mother to determine the mother's risk for HIV or viral hepatitis infection.
1b. If less than 5 years of age, was the child breastfed within the past 12 months?	☐No ☐Yes	
2. Did she/he EVER have any tattoos or piercings?	☐No ☒Yes	Back of Neck – Heart w/ angel wings, (R) ear – heart Lock 2a. Document location of tattoo/ piercing on body. (L) side – this too shall pass + scroll (L) shoulder – butterfly 2b. If tattoo, was it received while in prison? ☒No ☐Yes 2c. When? ~2014 *If within past 12 months,* 2d. Were shared or non-sterile instruments, needles or ink used? ☐No ☐Yes 2e. Was the procedure performed outside the U.S. or Canada? ☐No ☐Yes

* The interviewer should mix the appropriate pronoun with other terms with which the historian can relate: the donor's given name; their nickname; inserting "your" father, mother, husband, wife, sister, brother, daughter, son, or child (as indicated).

LNH Tissue ID# 1712301

Donor Risk Assessment Interview

3. Where was she/he* born?		Lodi, CA
4. What was her/his* occupation?		Student, caterer
5. Did she/he* have any health problems due to exposure to toxic substances such as pesticides, lead, mercury, gold, asbestos, agent orange, etc.?	☒No ☐Yes	5a. Describe toxic substance and treatment.
6a. Did she/he* have a family physician or a specialist?	☐No ☒Yes	6a(i). When was her/his* last visit? 3 mo. ago. 6a(ii). Why? F/u Migraines 6a(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.): Boone clinic @ Little Creek
6b. Did she/he*use a medical facility a clinic or urgent care center?	☐No ☒Yes	6b(i). When was her/his* last visit? 3 mo. ago 6b(ii). Why? Migraines 6b(iii). Provide any contact information (e.g., name, group, facility, phone number, etc.): Boone clinic @ Little Creek
7a. Did she/he* take any prescription medication recently or on a regular basis?	☒No ☐Yes	7a(i). What was it and/or what was it used for? *If a steroid, such as prednisone, ask:* 7a(ii). How long? 7a(iii). What was the dose?
7b. Did she/he* take any non-prescribed medication or dietary supplements?	☐No ☒Yes	7b(i). What was it and/or what was it used for? Tylenol for HA

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LNH Tissue ID# 171230)

Donor Risk Assessment Interview

8. Did she/he* recently have any symptoms such as:	☒No	*If any answer in question 8 is "yes," "ask "when" this occurred and "describe symptoms and reasons," if known.*
8a. a fever?	☐Yes	8a(i). When? 8a(ii). Describe the fever and reasons.
8b. cough?	☒No	
	☐Yes	8b(i). When? 8b(ii). Describe the cough and reasons.
8c. diarrhea?	☒No	
	☐Yes	8c(i). When? 8c(ii). Describe diarrhea and reasons.
8d. swollen lymph nodes or glands in the neck, armpits or groin?	☒No	
	☐Yes	8d(i). When? 8d(ii). Describe swollen lymph nodes and reasons.
8e. weight loss?	☒No	
	☐Yes	8e(i). When? 8e(ii). Describe how much weight loss and reason(s).
8f. a rash?	☒No	
	☐Yes	8f(i). When? 8f(ii). Describe the rash and reasons.
8g. sores in the mouth or on the skin?	☒No	
	☐Yes	8g(i). When? 8g(ii). Describe the sores and reasons.
8h. night sweats?	☒No	
	☐Yes	8h(i). When? 8h(ii). Describe night sweats and reasons.

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LNH Tissue ID # 171230l

Donor Risk Assessment Interview

8i. severe headache?	☐No ☒Yes	8i(i). When? Today - past 6 days 8i(ii). Describe the severe headache and reasons. Migraine
8j. rapid decline in mental ability?	☒No ☐Yes	8j(i). When? 8j(ii). Describe rapid decline in mental ability and reasons.
8k. seizures?	☒No ☐Yes	8k(i). When? 8k(ii). Describe seizures and reasons.
8l. tremors?	☒No ☐Yes	8l(i). When? 8l(ii). Describe tremors and reasons.
8m. difficulty walking?	☒No ☐Yes	8m(i). When? 8m(ii). Describe difficulty walking and reasons.
9. Did she/he* have any allergies?	☒No ☐Yes	9a. What was she/he* allergic to? 9b. Describe reaction:
10. Did she/he* know anyone who had a smallpox vaccination?	☒No ☐Yes	10a. Was **that person** vaccinated within the past 2 months? ☐No ☐Yes *If yes,* 10a(i). Did she/he* have contact with this person which includes touching the vaccination site, handling bandages that cover it, or handling bedding, clothing, or any other material that came in contact with the vaccination site? ☐No ☐Yes *If yes,* 10a(i)a. Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? ☐No ☐Yes *If yes,* 10a(i)a(I). Explain:

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LnH Tissue ID# 171230/

Donor Risk Assessment Interview

11. In the past **12 months** was she/he* in lockup, jail, prison, or any juvenile correctional facility?	☒No ☐Yes	11a. How long? 11b. Where? 11c. Why?
12. In the past **12 months** was she/he* bitten or scratched by any pet, stray, farm or wild animal?	☒No ☐Yes	12a. What kind of animal? 12b. When? 12c. Did she/he* receive any medical treatment? ☐No ☐Yes *If yes,* 12c(i). By whom? 12d. Was the animal suspected of having rabies? ☐No ☐Yes 12e. Was the animal quarantined or tested? ☐No ☐Yes 12e(i). Which one? *If yes to tested,* 12e(ii). What was the result?
13. In the past **12 months** was she/he* told by a healthcare professional that they had a West Nile virus infection?	☒No ☐Yes	13a. When was she/he* diagnosed? *If this occurred within the past 4 months ask:* 13a(i). What was the name of the doctor/clinic?

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CnH Tissue ID# 1712301

Donor Risk Assessment Interview

14. In the past **12 months** did she/he* have any shots or immunizations, such as MMR, yellow fever, hepatitis B, flu, etc.?	☒No ☐Yes	14a. When? 14b. What kind was it? *If smallpox vaccinia is named, ask these questions:* 14b(I). Did she/he* experience any symptoms or complications such as a rash, fever, muscle aches, headaches, nausea, or eye involvement? ☐No ☐Yes *If yes,* 14b(I)a. When did these symptoms resolve? 14b(II). Did the scab fall off or was it picked off? 14b(II)a. When?
15. In the past **12 months** did she/he* get a tattoo, touch up of an old tattoo, or permanent makeup?	☒No ☐Yes	15a. Were shared or non-sterile instruments, needles or ink used? ☐No ☐Yes 15b. Was the procedure performed outside of the United States or Canada? ☐No ☐Yes *If yes,* 15b(I). Where?
16. In the past **12 months** did she/he* have acupuncture, ear or body piercing?	☒No ☐Yes	16a. Were shared or non-sterile instruments or needles used? ☐No ☐Yes 16b. Was the procedure performed outside of the United States or Canada? ☐No ☐Yes *If yes,* 16b(I). Where?

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CAT Tissue ID # 1712301

Donor Risk Assessment Interview

17a. In the past **12 months** did she/he* live with a person who has hepatitis?	☒No ☐Yes	17a(i). What type of hepatitis did **that person** have? 17a(ii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin? ☐No ☐Yes
17b. In the past **12 months** did she/he* live with a person who has tuberculosis?	☒No ☐Yes	17b(i). Describe what happened and when.
18. In the past **12 months** did she/he* come into contact with someone else's blood?	☒No ☐Yes	18a. Describe what happened and when: 18b. Was the other person involved known to have had, or suspected of having, HIV or hepatitis? ☐No ☐Yes
19. In the past **12 months** did she/he* have an accidental needle-stick?	☒No ☐Yes	19a. Describe what happened and when: 19b. Was the needle contaminated with blood from someone known to have had, or suspected of having, HIV or hepatitis? ☐No ☐Yes
As I described before, I want to remind you of the sensitive and personal nature of some of these questions. For medical and health reasons, we are required to ask these questions about all potential donors. Next, I will ask you about her/his* sexual history.		
20. In the past **12 months** did she/he* have a sexually transmitted infection such as syphilis, gonorrhea, chlamydia, genital herpes, or genital warts?	☒No ☐Yes	20a. What was it?

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Donor Risk Assessment Interview

For the next part, sexual activity and sex refer to any method of sexual contact including vaginal, anal, and oral. I will read each question and you should answer to the best of your knowledge with a 'Yes' or 'No'.

21. In the past **5 years** was she/he* sexually active, even once?

☐No

☒Yes

If yes, complete the following questions (21a. to 21g.)

21a. Did she/he* have sex in exchange for money or drugs?

☒No

☐Yes *If yes,*

21a(I) When?

21b. **MALE DONOR only:** Did he have sex with another male?

☒(N/A) Donor is Female

☐No

☐Yes *If yes,*

21b(i). When?

21c. Did she/he* have sex with a person who has had sex in exchange for money or drugs?

☒No

☐Yes *If yes,*

21c(I). When?

21d. **FEMALE DONOR only:** Did she have sex with a male who had sex with another male?

☐ (N/A) Donor is Male

☒No

☐Yes *If yes,*

21d(i). When?

21e. Did she/he* have sex with a person who used a needle to inject drugs that were not prescribed by their own doctor?

☒No

☐Yes *If yes,*

21e(I). When?

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Donor Risk Assessment Interview

21f. Did she/he* have sex with a person who has received medication for a bleeding disorder such as hemophilia?

☒No

☐Yes *If yes,*

21f(i). Do you know the name of the medication?

☐No

☐Yes *If yes,*

21f(i)a. What was it?

21f(ii). Was the medication human derived?

☐No

☐Yes

21f(iii). When was it used?

21g. Did she/he* have sex with a person who had a positive test for, or was suspected of having, Hepatitis B, Hepatitis C, or HIV?

☒No

☐Yes *If yes,*

21g(i). Which virus and when?

21g(ii). Was that person sick from the virus during that time, such as having abdominal pain, joint pain, exhaustion, fever, nausea, vomiting, diarrhea, or yellowing of the eyes or skin?

☒No

☐Yes

21h. Is this DRAI for Mother of pediatric donor?

☐No (This DRAI is *not* for the mother of the donor.)

☒Yes *If yes,*

21h(i). During this pregnancy, did she have sex with a man diagnosed with a Zika Virus infection?

☒No

☐Yes *If yes,*

21h(i)a. When was he diagnosed?

21h(i)b. Did he travel to or reside in an area with active transmission of Zika Virus?

☒No

☐Yes *If yes,*

21h(i)b. When was it?

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Donor Risk Assessment Interview

22. In the past **5 years** did she/he* receive medication for a bleeding disorder such as hemophilia?	☒No ☐Yes	22a. When? 22b. What was the reason? 22c. Do you know the name of the medication? ☐No ☐Yes *If yes,* 22c(i). What was it? 22d. Was the medication human derived? ☐No ☐Yes
23. Did she/he* **EVER** use or take drugs, such as steroids, cocaine, heroin, amphetamines, or anything **NOT** prescribed by her/his* doctor?	☒No ☐Yes	23a. What was it? 23b. How often and how long was it used? 23c. When was it last used? 23d. Were needles used? ☐No ☐Yes *If no,* 23d(i). How was it taken?
24a. Did she/he* **EVER** have a transplant or medical procedure that involved being exposed to <u>live</u> cells, tissues or organs from an animal?	☒No ☐Yes	24a(i). Explain:
24b. Did she/he* live with, or have sex with, a person who had?	☒No ☐Yes	24b(i). Explain:
25. Was she/he* **EVER** told by a physician that she/he* had a disease of the brain or a neurological disease such as Alzheimer's, Parkinson's, multiple sclerosis, or epilepsy?	☒No ☐Yes	25a. What was she/he* told by a physician?

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Donor Risk Assessment Interview

26. Was she/he* **EVER** refused as a blood donor or told not to donate?	☒No ☐Yes	26a. What was the reason?
27. Did she/he* **EVER** have any kind of surgery?	☐No ☒Yes	27a. What kind? Knee surgery x2- 2002 2004 removed scar tissue 27b. Where? Sacramento, CA 27c. When? 2002, 2004
28. Did she/he* **EVER** travel or live outside of the United States or Canada?	☒No ☐Yes	28a. Where? 28b. When and for how long? 28c. Did she/he* **EVER** receive a blood transfusion or other medical treatment outside of the United States or Canada? ☐No ☐Yes *If yes,* 28c(i). What occurred (which one)? 28c(ii). Describe where and when: *If international travel or residency is extensive, be aware of query regarding vaccinations or other shots (within the past 12 months) at question #14.*

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Donor Risk Assessment Interview

29. Was she/he* **EVER** a U.S. military member, a civilian military employee, or a dependent of either?	☐No ☒Yes	29a. Did she/he* ever live or work on a U.S. military base outside the United States? ☒No ☐Yes *If yes,* 29a(i). In which country or countries? 29a(ii). When? *If this occurred between 1980 and 1997 in Europe:* 29a(ii)a. How long? *(estimate total time)* *If in the military in the past 12 months, be aware of query regarding vaccinations or other shots at question #14.*
30. Did she/he* **EVER** use or take growth hormone?	☒No ☐Yes	30a. When was it used? 30b. What kind was it?
31. Did she/he* **EVER** have a positive or reactive test for:		
31a. the HIV/AIDS virus?	☒No ☐Yes	31a(i). Explain:
31b. hepatitis?	☒No ☐Yes	31b(i). Explain:
31c. HTLV-I or HTLV-II?	☒No ☐Yes	31c(i). Explain:
31d. *T. cruzi* or told she/he* has Chagas' disease?	☒No ☐Yes	31d(i). Explain:
32. Did she/he* **EVER** have liver disease or hepatitis?	☒No ☐Yes	32a. What kind? 32b. When?

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LNH Tissue ID# 171230|

Donor Risk Assessment Interview

33. Did she/he* **EVER** have malaria?	☒No ☐Yes	33a. When? 33b. Where was she/he* treated?
34. Did she/he* **EVER** have cancer?	☒No ☐Yes	34a. What type? *If skin cancer:* 34a(i). What kind? 34b. When was it diagnosed? 34c. Describe when and where surgery, radiation, or chemotherapy occurred: 34d. Was the cancer considered cured? ☐No ☐Yes *If yes,* 34d(i). When?
35. Did she/he* **EVER** smoke?	☒No ☐Yes	35a. What was it? *If cigarettes:* 35a(i). How many packs per day? 35b. How many years? 35c. Did she/he* quit? ☐No ☐Yes *If yes,* 35c(i). When?
36a. Did she/he* **EVER** have lung disease such as asthma, COPD, or emphysema?	☒No ☐Yes	36a(i). Explain:

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Donor Risk Assessment Interview

36b. Did she/he* **EVER** have tuberculosis, or a positive skin or blood test for tuberculosis?	☒No ☐Yes	36b(i). Did she/he* receive treatment? ☐No ☐Yes *If yes,* 36b(i)a. When? 36b(i)b. How long?
37. Did she/he* **EVER** drink alcohol?	☐No ☒Yes	currently, no d/t pregnancy 37a. What type? wine/beer/liquor 37b. How often? 1 x/week 37c. How much? 1 drink 37d. How long? since ~21 ~9yrs.
38. Did she/he* **EVER** have diabetes?	☒No ☐Yes	38a. For how many years? 38b. Was it treated? ☐No ☐Yes *If yes,* 38b(i). How?
39a. Did she/he* **EVER** have kidney disease, kidney stones, or frequent kidney infections?	☒No ☐Yes	39a(i). What did she/he* have? 39a(ii). When?
39b. Was she/he* **EVER** treated with dialysis?	☒No ☐Yes	39b(i). Was it peritoneal dialysis or hemodialysis? 39b(ii). When?
40. Did he/she* **EVER** have high blood pressure or high cholesterol?	☒No ☐Yes	40a. Which one (or both)? 40b. For how many years?

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Donor Risk Assessment Interview

41. Did she/he* **EVER** have heart problems or heart disease, such as a weak heart, a heart valve problem or an infection involving the heart?	☒No ☐Yes	41a. Explain: 41b. How was it treated?
42. Did she/he* **EVER** have circulation problems of the legs, such as varicose veins, blood clots, leg ulcers, or skin discoloration of the feet or ankles?	☒No ☐Yes	42a. Explain:
43. Did she/he* **EVER** have an autoimmune disease such as systemic lupus erythematosis, rheumatoid arthritis, sarcoidosis, etc.?	☒No ☐Yes	43a. What was it? 43b. Did she/he* take steroids? ☐No ☐Yes *If yes, complete 7a(ii) and 7a(iii).*
44. Did she/he* **EVER** have any eye problems, procedures, or surgery?	☒No ☐Yes	*If yes to eye problems:* 44a. What kind of eye problems? *If yes to eye surgery or procedures:* 44b. What kind of surgery or procedure was performed and why? 44c. Which eye(s)? ☐ left ☐ right ☐ unknown 44d. What is the name and/or phone number of her/his* eye doctor or eye clinic?

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Donor Risk Assessment Interview

45. Did she/he* or **any** of her/his* relatives have Creutzfeldt-Jakob disease, which is also called CJD or variant CJD?	☒No ☐Yes	45a. Who did? *If a relative,* 45a(I). Is this person a blood relative? *(Note: The definition of blood relative is a person who is related through a common ancestor and not by marriage or adoption)* ☐No ☐Yes *If yes,* 45a(II). Which blood relative? 45b. Is there a physician, relative, or other person who can provide more information? *(document discussion)*
46a. Did her/his* family have a history of diabetes?	☒No ☐Yes	46a(I). Describe type of relative, such as mother, father, sister, brother, etc.:
46b. Did her/his* family have a history of coronary artery disease, which is a buildup of plaque in the heart's arteries?	☒No ☐Yes	46b(I). Describe type of relative, such as mother, father, sister, brother, etc.:
47. Was she/he* told by a healthcare professional she/he* was infected with the Ebola virus?	☒No ☐Yes	47a. When was she/he* diagnosed?
48. Was she/he* told by a public health authority she/he* could have been exposed to the Ebola virus?	☒No ☐Yes	48a. When did monitoring begin of her/his* health?
49. Was she/he* told by a healthcare professional she/he* was infected with the Zika Virus?	☒No ☐Yes	49a. When was she/he* diagnosed? 49b. Provide any contact information for the healthcare professional (e.g., name, group, facility, phone number, etc.):

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LNH Tissue ID# 1712301

Donor Risk Assessment Interview

50. Did she/he* recently have any symptoms such as:		
50a. joint pain?	☒No ☐Yes	50a(i). When? 50a(ii). Describe the joint pain and reasons.
50b. conjunctivitis, which is also called "pink eye" or "red eye"?	☐No ☒Yes	50b(i). When? when she was 13 yo. 50b(ii). Describe the conjunctivitis and reasons. "pink eye" @ age 13, "got at school"
51. Describe any of her/his* travel within the past 6 months.	☒No ☐Yes	*(If yes, document areas traveled to during the past 6 months.)*
Final Questions		
52. Are there other medical conditions you are aware of that we have not discussed?	☒No ☐Yes	52a. Describe:
53. Do you now have any concerns that her/his* donation should not proceed?	☒No ☐Yes	53a. Can you share your concerns?
54. Regarding these questions, are there other people, including healthcare professionals, who may provide additional information?	☒No ☐Yes	54a. Name(s) and contact information:
55. Do you have any questions about these questions?	☒No ☐Yes	55a. Document:

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LifeNet Health
Saving Lives. Restoring Health. Giving Hope.

QC Laboratory

1864 Concert Drive
VIRGINIA BEACH, VA 23453
1-757-609-4150

CLIA ID # 49D0883917
Laboratory Medical Director: [redacted]

DONOR ID#	EyeBank	UNOS#	SAMPLE ID	PROVIDER
1712301			H1708014	[redacted]

TRID/Z#	ClientNum	AGENCY	COLLECTION DATE	RESULTS	PAGE
		LTS	3/9/2017 16:45	3/10/2017 02:47	1

Plasma archive volume 2.0 ml
Serum archive volume 2.0 ml

Blood Sample: Maternal

TEST NAME	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE
HBsAg				
BioRad GS HBsAg EIA 3.0				
Hepatitis B Surface Antigen	Non Reactive			Non Reactive
HCV Ab				
Ortho® HCV Ver 3.0 ELISA Test System				
Hepatitis C Antibody	Non Reactive			Non Reactive
HIV Ab				
BioRad GS Systems HIV-1/HIV-2 Plus O EIA				
HIV-1/HIV-2 Plus O Antibody	Non Reactive			Non Reactive
HBcAb				
Ortho® HBc ELISA Test System				
Hepatitis B Total Core Antibody	Non Reactive			Non Reactive
RPR				
ASiManager-AT RPR Card Test for Syphilis				
RPR	Non Reactive			Non Reactive
CMV Ab				
Immucor Capture-CMV® IgG and IgM				
CMV Antibody		Positive (A)		Negative
NAT PANEL				
Roche Cobas TaqScreen MPX Test, Version 2.0				
HIV-1 NAT	Non-Reactive			Non-Reactive
HBV NAT	Non-Reactive			Non-Reactive
HCV NAT	Non-Reactive			Non-Reactive

DONOR ID#: 1712301
END OF REPORT (Final)

LifeNet Health®
Saving Lives. Restoring Health. Giving Hope.

OPTN/UNOS #: ____________
LifeNet Health #: ____________

1864 Concert Drive, Virginia Beach, VA 23453
1-866-543-3638

LNH Tissue ID# 1712301

[redacted]

Patient Label

Authorization for the Donation of Organs and Tissues by Next of Kin

I/We, [redacted] (name of next of kin), as next of kin and mother (relationship) of [redacted] (name of donor) authorize these gifts as indicated below, if medically acceptable, to be used for the following purposes:

Transplantation and Medical Therapy [X] Yes [ ] No   Research [X] Yes [ ] No   Education [X] Yes [ ] No CSW 3/5/17 CSW(initials) *

Heart	[X] Yes	[ ] No	[ ] N/A
Recovery of Heart for Valves	[X] Yes	[ ] No	[ ] N/A
Lungs	[X] Yes	[ ] No	[ ] N/A
Kidneys	[X] Yes	[ ] No	[ ] N/A
Liver	[X] Yes	[ ] No	[ ] N/A
Pancreas	[X] Yes	[ ] No	[ ] N/A
Intestines	[X] Yes	[ ] No	[ ] N/A

~~Corneas~~ 3/9/17 CSW(initials)	[X] Yes	[ ] No	[ ] N/A
~~Eyes~~ 3/9/17 CSW(initials)	[X] Yes	[ ] No	[ ] N/A
Bone & associated tissue of the legs	[X] Yes	[ ] No	[ ] N/A
Bone & associated tissue of:			
The Upper Arms	[X] Yes	[ ] No	[ ] N/A
The Lower Arms	[X] Yes	[ ] No	[ ] N/A
Ribs	[X] Yes	[ ] No	[ ] N/A
Pericardium	[X] Yes	[ ] No	[ ] N/A
Skin	[X] Yes	[ ] No	[ ] N/A
Neurological Tissue	[X] Yes	[ ] No	[ ] N/A
Brain & associated tissue	[X] Yes	[ ] No	[ ] N/A

*1 (margin note)

*1 AUTHORIZATION FOR CORNEA + EYES OBTAINED ON 3/9/17

[ ] Other (specify) 3/10/17
[ ] Other (specify)

*OOEF TO RECOVER OUT OF REGION 3/9/17

Will your funeral plans include a viewing prior to cremation or burial? [X] Yes [ ] No [ ] Unknown [redacted]

Have you selected a funeral home? [ ] Yes [ ] No If Yes, name of funeral home? [redacted]

If directed donation is requested, please indicate the name of potential recipient as well as the transplant center, social security number and/or date of birth (if known). N/A

[ ] If the donated organs and/or tissue are not able to be used for any purpose authorized above, I would like to be notified: [ ] Yes [X] No

Authorization/Disclosure

I/We understand the following:

[X] The gift of organs and/or tissue donation is made to LifeNet Health, and the gift of corneas and/or eyes are made to the local eye bank, which are both non-profit organizations. Because this is a gift, you will not receive any financial benefit from this donation. The recovery, distribution and disposition of these gifts will be coordinated by LifeNet Health and/or its affiliated agencies. This is done in accordance with medical and ethical standards. Affiliated agencies may be for-profit organizations. These gifts may be distributed outside the United States.

[X] All costs associated with the recovery of organs and/or tissue are the responsibility of LifeNet Health and/or its affiliated agencies.

[X] Despite LifeNet Health's best efforts, a change in appearance and/or a delay in the funeral arrangements may occur. LifeNet Health will make every effort to minimize any visual change to your loved one's body and will make every effort to minimize any delay in the funeral arrangements.

[X] Blood samples will be collected to test for certain transmissible diseases such as hepatitis and HIV viruses. LifeNet Health will report any confirmed positive test results that may pose a health risk. Other examinations or procedures may be necessary including but not limited to the collection of blood or tissue samples for the purpose of biopsy or other testing required to ensure the acceptability and compatibility of these gifts. Recovery includes spleen and lymph nodes to ensure compatibility with potential transplant recipients; as well as the recovery of blood vessels to facilitate the implantation of the solid organs for transplantation.

[X] I/We understand that another surgical facility may be needed to carry out all or part of the organ and tissue recovery. I hereby give authorization for transportation as LifeNet Health deems appropriate.

~~I/We understand that in the event your loved one's heart stops prior to the identification of recipients, LifeNet Health and hospital staff will attempt to restore heart function in order to facilitate organ recovery.~~ N/A

[X] I/We authorize the release of medical information, to LifeNet Health and its affiliated agencies, including the death certificate, hospital records, physician office records and post mortem examination reports, if performed, to determine the suitability of the donated organs and/or tissue.

[X] **For authorized research donors only, read the following:**

- [X] Blood, lymph nodes and bone marrow may be recovered for research. Donated tissues or cells may be stored indefinitely and could be used for genetic research, transformed into different kinds of cells, or treated to grow forever.
- [X] Donated tissue/cells could lead to a discovery that could be patented, licensed or sold, and you will not receive any financial benefit. We may not be ale to inform you of any details about the research projects after the tissue and cells are recovered.
- [X] Relevant medical, behavioral and social history about your loved one and/or information about family history of genetic disease may be transferred with the donated tissues to research organizations. There is a very small chance the donor and the blood relatives of the donor could be identified. Every effort will be made to ensure confidentiality of your loved one's information.
- [X] You can change your mind and withdraw **any unprocessed** tissue by contacting LifeNet Health. Any tissue stored in our possession that has not yet been used for research will be destroyed and never used again. However, you cannot stop samples and information from being used that have already been sent to researchers.

[X] I/We have had the opportunity to ask questions concerning the donation and recovery of the organs and/or tissues and my questions have been answered. I have had the opportunity to read this document and understand it.

WITNESS: [redacted]

The authorization for donation was explained by:

[redacted] (print name) [redacted] (signature)

Date/Time: 3/7/17 1620

LEGAL NEXT OF KIN:

Email Address: [redacted]

Signature: [redacted]

Name: [redacted]

Relationship: mother   Phone: [redacted]

Street: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]