SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

NHS Blood and Transplant

# Authorisation - Solid Organ and Tissue Donation

## Directions for completion

1. This form should be completed in **black/blue ink** by the Specialist Nurse - Organ Donation (SN-OD)/Tissue Donor Co-ordinator (TDC)/Nurse Practitioner (NP) and signed and dated as appropriate. Copy as described below
2. The original copy should be retained by the **SN-OD/TDC/NP**
3. If tissue is retrieved, **a copy** should be sent as soon as possible to the Tissue and Cells Services, Scottish National Blood Transfusion Service (SNBTS) via secure e-mail to NSS.SNBTS-Tissues-Seniors@nhs.scot A copy should also be sent to other tissue establishments as appropriate.
4. A copy should be offered to the **nearest relative**
5. A copy should be retained by the **donating centre in the hospital records**

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In the case of deceased adults, nearest relatives are ranked in the following order:

a) the adult's spouse or civil partner
b) living with the adult as husband or wife or in a relationship which had the characteristics of the relationship between civil partners and had been so living for a period of not less than 6 months (or if the adult was in hospital immediately before death had been so living for such period when the adult was admitted to hospital)
c) the adult's child
d) the adult's parent
e) the adult's brother or sister
f) the adult's grandparent
g) the adult's grandchild
h) the adult's uncle or aunt
i) the adult's cousin
j) the adult's niece or nephew
k) a friend of longstanding of the adult

**NOTES:**

1 The term "patient" is used throughout the form to refer to the potential donor.

2 Authorisation in respect of a child:

- **A child aged 12 years or over** is able to self authorise in life.
- **A child who dies under 12 years of age, or over 12 where no self-authorisation exists,** must have authorisation obtained from the person with parental rights and responsibilities (PRR).
  In circumstances where both parents are dead the appointment of a legal guardian may have been made.

## Authorisation

Unique Tissue Number [ ][ ] [ ][ ] [ ][ ] [ ][ ]   ODT Donor number [ ][ ][ ][ ][ ][ ]

**PATIENT/GENERAL PRACTITIONER DETAILS** — **Section 1**

Surname

Forename

Address

Postcode

CHI number:
(Scotland)

GP name

Address

Postcode

Telephone number

Fax number

Date of birth

Age
*(If under 12 years record years and months)*
years   months   (Gestational) weeks

NHS/Hospital number:

Has the Procurator Fiscal (PF) given consent for donation?
*(Initial as appropriate)*

Yes [ ]   No [ ]   Pending [ ]   Not Required [ ]

Please provide details below and specify any instructions or restrictions stated by the Procurator Fiscal and/or the Fiscal's Pathologist

**SELF-AUTHORISATION** — **Section 2**

**Please initial appropriate box**

| | **Yes*** | **No** | **Unknown** | **N/A** | **Restricted** | **Unrestricted** |
|---|---|---|---|---|---|---|
| Did the patient make a decision regarding organ/tissue donation?<br>** If Yes, see section 4* | | | | | | |
| Was the decision to donate organs/tissue ? | | | | | | |

If yes, by what method? (**delete as appropriate)   Organ Donor Register/Donor Card/Expressed Decision/Will**

**AUTHORISATION VIA TELEPHONE (If Applicable)** — **Section 3**

Obtaining authorisation via telephone is in accordance with the Human Tissue (Scotland) Act 2006 – it is not a legal requirement for relatives to sign an authorisation form.

However the interviewer **must** ask the following and **initial** the appropriate boxes:

**Please initial the appropriate box**

| | Yes | No |
|---|---|---|
| Do you agree to the conversation about donation between NHSBT/SNBTS and you being voice recorded?<br>The recording will be stored as evidence of the information that I give to you and of the responses and information that you give to me. | | |
| May we use the recording and case details for training purposes? | | |

For the purpose of the recording can you tell me again your full name and relationship to (name of the patient)?

Name:   Relationship:

## Authorisation

Unique Tissue Number [ ][ ] [ ][ ] [ ][ ] [ ][ ]

ODT Donor number [ ][ ][ ][ ][ ][ ]

**SPECIFIED ORGANS AND/OR TISSUE FOR DONATION** **Section 4**

**Please initial appropriate box**

| | Yes | No | Exclusion | PF Restriction |
|---|---|---|---|---|
| Kidneys | | | | |
| Liver | | | | |
| Liver for hepatocytes | | | | |
| Heart | | | | |
| Heart for Valves | | | | |
| Lungs | | | | |
| Pancreas | | | | |
| Pancreas for Islet Cells | | | | |
| Bowel | | | | |
| Multivisceral* | | | | |
| Other** | | | | |
| Eyes | | | | |
| Tendons | | | | |
| Skin | | | | |
| Blood vessels | | | | |
| Other Tissue*** | | | | |

* If yes, please specify explicitly

**If yes, please specify explicitly

*** If yes, please specify explicitly

Blood samples, lymph nodes and spleen — **Removal** Yes [ ] No [ ] — **Storage** Yes [ ] No [ ]

Additional Information:

NHS Blood and Transplant

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

# Authorisation

Unique Tissue Number ☐☐ ☐☐ ☐☐ ☐☐ ODT Donor number ☐☐☐☐☐☐

## ADDITIONAL INFORMATION — Section 5

**I understand that for donation to proceed:**

Please initial appropriate box

| | Yes | No | N/A |
|---|---|---|---|
| Blood samples will be taken from the patient (and the patient's mother where the patient is under 18 months old **and/or** if the child has been breast fed in the last 12 months) for testing, including pregnancy (for organ donors only, if applicable), tissue typing, blood borne infections such as HIV and Hepatitis and other relevant infectious agents and subsequently stored. In the event of a confirmed positive result, relevant individuals will be contacted if their health could be affected. | ☐ | ☐ | ☐ |
| Donated tissue will be stored until required for transplantation. | ☐ | | ☐ |
| Tissue may need to be sampled and/or biopsied, analysed and subsequently stored in support of safe transplantation, following which this tissue will be disposed of in a safe and lawful way. | ☐ | ☐ | |
| The patient's hospital records have/will be accessed by relevant healthcare professionals and the General Practitioner of the patient has/will be approached for medical history to support safe transplantation. | ☐ | ☐ | |
| The information collected from you on this form will be stored securely. Additionally, information may be passed onto other healthcare professionals in support of a safe transplantation process. | ☐ | ☐ | |

**The following information must be discussed where applicable**

| | Yes | No | N/A |
|---|---|---|---|
| Do you agree to the patient being transferred from their place of death to the dedicated donation facility for the tissue donation procedure to be undertaken (NB This should not delay the funeral arrangements). | ☐ | ☐ | ☐ |

## AUTHORISATION FOR PURPOSES OTHER THAN TRANSPLANTATION — Section 6

This refers to organs/tissue removed specifically for research and/or organs and tissue removed for transplantation but then found to be unsuitable for clinical use including surplus tissue removed as part of the transplantation process. Organs, tissue and /or samples will be used and stored in accordance with the Human Tissue (Scotland) Act 2006.

**Other purposes include**: Research Education and Training Audit

| | | Yes | No |
|---|---|---|---|
| 1. | There is also an opportunity to support transplantation/healthcare through the removal of samples, for example blood, urine and/or tissue samples from specific organs which can then be used in approved research projects. Do you believe the patient would agree to this and do you authorise? | ☐ | ☐ |
| 2. | On occasion, organs/tissue you have agreed to donate may be found to be unsuitable when removed for transplant. However, these organs/tissue can be used in research to improve healthcare in the future. Do you authorise this? | ☐ | ☐ |

3. Organs/tissue/samples may also be donated and used to improve future healthcare. Do you authorise the removal and storage of specific organ/tissue/samples for research and other purposes? If relevant, provide detail in the 'additional information' box in **Section 7**

| **A.** | **Yes** | **No** | **N/A** |
|---|---|---|---|
| Heart | ☐ | ☐ | ☐ |
| Lungs | ☐ | ☐ | ☐ |
| Diabetic Pancreas | ☐ | ☐ | ☐ |
| **B**. Centre Specific Studies | ☐ | ☐ | ☐ |

Research leaflet (INF1167) offered to family: **Accepted** ☐ **Declined** ☐ **N/A** ☐

Organs and tissue may be stored and used for education/training, do you authorise? Yes ☐ No ☐

Organs and tissue may be stored and used for audit of clinical services, do you authorise? Yes ☐ No ☐

Any research restriction or any other purposes restrictions? Yes ☐ No ☐ N/A ☐

If yes, please provide detail

I agree that following either completion of research, education and training, audit or if found unsuitable for clinical use all organs, tissue and/or samples will be disposed of in a safe and lawful way ☐

**NHS**
**Blood and Transplant**

## Authorisation

Unique Tissue Number | | | | | | | | |

ODT Donor number | | | | | | |

**ADDITIONAL INFORMATION** **Section 7**

***RESEARCH PAGE FOR 2 STICKERS***

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Unique Tissue Number ☐☐ ☐☐ ☐☐ ☐☐ ODT Donor number ☐☐☐☐☐☐

**CONFIRMATION OF AUTHORISATION** **Section 8**

Where self authorisation has been given, was authorisation obtained from the nearest relative or person with parental rights and responsibilities, for other purposes other than transplantation?

YES ☐ NO ☐ If No, please explain in 'additional comments section below Relationship: ☐

Where self authorisation has not been given, was authorisation obtained from the nearest relative or person with parental rights and responsibilities?

YES ☐ NO ☐ If No, please explain in 'additional comments' section below Relationship: ☐

I have read and understood this document and I have had the opportunity to ask and have had my questions answered

Signed ☐ Name ☐ Please print

Date ☐☐ ☐☐ 2 0 ☐☐ Time *(24 hrs)* ☐☐ : ☐☐

Address of person **giving** authorisation
*(Where applicable)*

Telephone number ☐☐☐☐☐☐☐☐☐☐☐☐

Mobile ☐☐☐☐☐☐☐☐☐☐☐☐

Co-signatories *(Where applicable)*

**Healthcare Professional Details** (Witness)

**Designation** ☐

Signed ☐ Name ☐

Date ☐☐ ☐☐ 2 0 ☐☐ Time *(24 hrs)* ☐☐ : ☐☐

| | Accepted | Declined |
|---|---|---|
| **Copy of authorisation form offered** | ☐ | ☐ |

**SNOD/TDC/NP obtaining authorisation via telephone*/in person* (delete as appropriate)***

Where authorisation was obtained over the telephone the content of this document has been discussed with the person giving authorisation documented above and they have had the opportunity to ask and have their questions answered.

**Designation** SN-OD/TDC/NP* *(*Delete as appropriate)*

Signed ☐ Name ☐ Please print

Date ☐☐ ☐☐ 2 0 ☐☐ Time *(24 hr)* ☐☐ : ☐☐

Additional comments