



# FRM1538/10 – Authorisation - Solid Organ and Tissue Donation



Blood and Transplant

Effective date: 20/09/2022

Tissue Donor Number

ODT Donor Number

## NOTES

## Section 1

- The "patient" is used throughout the form to refer to the potential donor.
- If tissue is being retrieved, a copy should be sent as soon as possible to Tissues, Cells and Advanced Therapeutics (SNBTS - TCAT) via secure e-mail to [nss.snbtstissues-seniors@nhs.scot](mailto:nss.snbtstissues-seniors@nhs.scot) A copy should also be sent to other tissue establishments as appropriate.
- References in this document to the Human Tissue (Scotland) Act 2006 are to the Act as amended by the Human Tissue (Authorisation) (Scotland) Act 2019.
- Please refer to INF1370 (Rationale for Authorisation – Solid Organ and Tissue Donation).

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

- the adult's spouse or civil partner (except in the case of permanent separation or desertion)
- 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)
- the adult's child (including stepchild)
- the adult's parent
- the adult's brother or sister
- the adult's grandparent
- the adult's grandchild
- the adult's uncle or aunt
- the adult's cousin
- the adult's niece or nephew
- a friend of longstanding of the adult

Relatives of the half-blood are ranked equally with relatives of the full-blood, except in the case of siblings of the potential donor.

If Authorisation is being sought on behalf of a child (under 16 years of age), it must be obtained from a person holding parental rights and responsibilities (PRRs) in relation to the child (including a local authority). If there is no such person, or they are incapacitated, refer to section 10A of the Human Tissue (Scotland) Act 2006.

## AUTHORISATION VIA VIRTUAL OR REMOTE TECHNOLOGY (if applicable)

## Section 2

Obtaining authorisation for donation to proceed via telephone / remote technology 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:

Do you agree to the conversation about donation between NHSBT / SNBTS and you being voice recorded?

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.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

May we use the recording and case details for training purposes?

<input type="checkbox"/>	<input type="checkbox"/>
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For the purpose of the recording can you tell me again your full name and relationship to (name of the patient)?

Name:  Relationship:

## CONFIRMATION OF NEAREST RELATIVE STATUS / PERSON ENTITLED TO AUTHORISE ON BEHALF OF A CHILD

## Section 3

Please provide details how the nearest relative / person entitled to authorise on behalf of a child has been identified

## PATIENT and GENERAL PRACTITIONER DETAILS

## Section 4

Surname	<input type="text"/>	GP Name	<input type="text"/>
Forename	<input type="text"/>	Address	<input type="text"/>
Address	<input type="text"/>		<input type="text"/>
	<input type="text"/>		<input type="text"/>
Postcode	<input type="text"/>	Postcode	<input type="text"/>
	<input type="text"/>	Tel No	<input type="text"/>
CHI Number (Scotland)	<input type="text"/>	NHS/Hospital Number	<input type="text"/>
Date of birth	<input type="text"/>	Age	<input type="text"/>
	<input type="text"/>	Weeks (Corrected Gestational Age)	<input type="text"/>

Please provide details of faith, religious and/or cultural considerations influencing the donation process



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## PROCURATOR FISCAL (PF)

Section 5

Has the Procurator Fiscal (PF) given consent for donation?

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

## DUTY TO INQUIRE

Section 6

Do you have any reason to believe that  would have been unwilling to be a donor? Yes  No

For donation to proceed some routine tests/procedures need to be carried out. These may include blood tests/procedures, urine tests and imaging, for example an Ultrasound Scan, X-rays. This is to allow the matching of organs, exclude infections and ensure organs/tissue can be safely transplanted. Do you have any reason to believe they would have been unwilling to have these tests/procedures carried out? Yes  No  N/A

If the nearest relative, or the person entitled to authorise on behalf of a child, is authorising donation: Do you authorise these tests/procedures?

Is there anyone else you think can provide more recent information? If yes, give detail below:

## AUTHORISATION FOR DONATION FOR TRANSPLANTATION OF ORGANS AND TISSUE (Please complete either A, B or C)

Section 7

Complete A if the patient is giving / has given Express Authorisation  
Complete B if Authorisation is able to be deemed in accordance with the Acts (detailed in Section 1).  
Complete C if Authorisation is given by the nearest relative or person entitled to authorise on behalf of a child

### A – EXPRESS AUTHORISATION

Name

gave / gives Authorisation for the following organs/tissue to be donated for transplantation (detailed in section 8) via Organ Donor Register / Written Expressed Decision (please circle the appropriate option).

### B – DEEMED AUTHORISATION

Name

is deemed to have given their Authorisation for donation of the following organs/tissue (detailed in section 8) for transplantation under the Human Tissue (Scotland) Act 2006.

The following safeguards have been confirmed Age (16+)  Capacity (To have understood Deemed Authorisation)  Residence (12 Months)

### C – AUTHORISATION FOR DONATION FOR TRANSPLANTATION GIVEN BY NEAREST RELATIVE / PERSON ENTITLED TO AUTHORISE ON BEHALF OF A CHILD

Name  the  of

gives Authorisation for the following organs/tissue to be donated (detailed in section 8) for transplantation. Yes  No

Additional comments



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## SPECIFIED ORGANS AND / OR TISSUE FOR DONATION FOR TRANSPLANTATION

Section 8

Please initial appropriate box. If NO, please details reason in additional boxes.

	Yes	No	Family Exclusion / Override	Clinical Exclusion	PF Restriction	
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver for Hepatocytes	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart for Tissue	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pancreas for Islet Cells	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multivisceral <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<sup>1</sup> If yes, please specify explicitly <input type="text"/>
Other <sup>2</sup> (Incl Excepted Body Parts)	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<sup>2</sup> If yes, please specify explicitly <input type="text"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<sup>3</sup> If yes, please specify explicitly <input type="text"/>
Tendons	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Tissue <sup>3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Removal Yes  No

Storage Yes  No

Samples of blood, lymph nodes and spleen

The following information must be discussed where applicable

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? (N.B. This should not delay the funeral arrangements.)

Yes  No  N/A

Additional Information:

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## INFORMATION REQUIRED TO SUPPORT ORGAN AND TISSUE DONATION FOR THE PURPOSE OF TRANSPLANTATION

Section 9

I understand that for donation to proceed:

- Blood samples taken from the patient are tested (and the child's birth mother where the patient is under 18 months old **and/or** if the child has been breast fed in the last 12 months) including for 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 for potential future testing. In the event of a confirmed positive result, relevant individuals will be contacted if their health could be affected.
- Blood vessels will also be removed and sent with the organs in order to support the transplantation surgery.
- Donated tissue will be stored until required for transplantation.
- In order to support safe transplantation, samples/biopsies may be taken for analysis and subsequently stored for potential further testing. When such samples/biopsies or other material are no longer required or are unsuitable for clinical use they will be disposed of in accordance with the hospital / tissue establishment policy.
- The patient's **healthcare** records are accessed by relevant healthcare professionals and the General Practitioner of the patient is approached for medical history to support safe transplantation.
- The information collected on this form will be stored securely. Additionally, information may be passed onto other healthcare professionals in support of a safe transplantation process. Yes  No

## AUTHORISATION FOR DONATION PURPOSES OTHER THAN TRANSPLANTATION (DEEMED AUTHORISATION DOES NOT APPLY)

Section 10

(Other purposes are Research, Education & Training, Audit and Quality Assurance)

This refers to organs/tissue removed specifically for research or the other purposes 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 in accordance with the Human Tissue (Scotland) Act 2006 and stored appropriately. Do you have any reason to believe they would have been unwilling to donate for these purposes? Yes  No

For QUOD DCD Donors Only – Does this patient have a Welfare Guardian or Welfare Attorney? Yes  No  N/A

[If the patient has a Welfare Guardian/Attorney no QUOD samples are to be taken pre or post theatre.]

- There is 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 authorise this? Yes  No  N/A
- On occasion, organs/tissue donated for transplantation may be found to be unsuitable once removed. These organs/tissue can be used in research or other purposes (education and training, audit, quality assurance) to improve healthcare in the future. Do you authorise this? Yes  No
- Organs and tissue may also be donated and used to improve future healthcare. Do you authorise the removal and use of specific organ and tissue samples for research and the other purposes (education and training, audit, quality assurance)? If relevant, provide detail in the 'additional information' box. Yes  No  N/A

A.	Yes	No	N/A
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Centre Specific Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### For SNBTS Personnel Only: For Tissue

	Research	E&T	Audit	QA
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Research Leaflet (INF1167) offered to family

Accepted  Declined  N/A

Any restrictions to research, education and training, audit or quality assurance?

Yes  No  N/A

If yes, please provide detail

I agree that following completion of other purposes, organs/tissue and/or samples will be disposed of in a safe and lawful way. Yes  No

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## ADDITIONAL INFORMATION

Section 11



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## DECLARATION

Section 12

I have understood the information provided and have had the opportunity to ask and have had my questions answered.

Signed

Name:

Date

Time (24hrs)

Address

Telephone Number

Mobile Number

Postcode

Co-signatories (Where applicable)

### Healthcare Professional Details (Witness)

Designation

Signed

Name:

Date

Time (24hrs)

### TRAINED INDIVIDUAL Obtaining authorisation for donation to proceed via telephone remote technology / in person

Where authorisation was obtained for donation to proceed via telephone / remote technology, the content of this document has been discussed with the person giving authorisation above and they have had the opportunity to ask and have had their questions answered

Designation

Signed

Name:

Date

Time (24hrs)

## ONLY COMPLETE IF TYPE B TESTS / PROCEDURES ARE REQUESTED

Section 13

On occasion, additional tests / procedures (Type B) as discussed and detailed below may be requested.

Do you have any reason to believe they would have been unwilling to have these tests / procedures carried out? Yes  No

Has the carrying out of the specified Type B tests / procedures been authorised? Yes  No

Additional Test / Procedure (Type B) description	Date and Time	Signature

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