NETHERLANDS BRAIN BANK

This document is a translation of the Dutch NBB authorization form used by representatives of legally incompetent persons. This translation is ONLY to inform researchers about the NBB's informed consent and is not to be used for donor registration.

Do not fill in
Codicil code:
Codicil number:

Registration form for the Netherlands Brain Bank

For representatives of incompetent persons

Name donor _____ _____ ☐ male ☐ female

First names _____

Date of birth _____

Name of the donor's residence (e.g. nursing home, if applicable) _____

Address _____

Postal code and city _____

Phone number _____

Clinical diagnosis _____

Name of treating physician _____

I have read and understood the information regarding the procedure of donation of tissue to the Netherlands Brain Bank. I give this authorization as a representative of the incompetent person, because he/she is permanently incapable to understand the information given in a form adjusted to his/her capabilities, to the extent that is needed to make a decision about post-mortem brain donation for scientific research purposes. I am not aware that before becoming incompetent, the person has ever objected to or had any beliefs which would forbid post-mortem donation of tissues fo r scientific research or otherwise forbid post-mortem interventions.

I may act as a representative of _____ *(name of the incompetent person)*, because *(please check the relevant box)*:

☐ I have been appointed by the court of law as a curator/mentor[1] of that person (please attach a copy of the judicial appointment);

☐ I have been appointed as a representative by the person before he/she became incompetent (please attach a copy of the written appointment);

☐ I am the next of kin of the incapable person, (please specify relationship) _____

☐ The donor is a minor who is permanently incompetent, of whom I am a parent

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I hereby authorize the Netherlands Brain Bank to perform a post-mortem autopsy on the registered donor, to remove the following bodily material and to store this material for an indefinite period of time to be used in scientific research:

Please check: Optional (only possible in combination with brain donation):

☐ Brain ☐ Eyes ☐ Spinal cord

- The medical (and, if applicable, psychological) records may be requested at the treating physician's office for viewing by the employees of the Netherlands Brain Bank.
- The medical records may be processed by the employees of the Netherlands Brain Bank and stored for an indefinite period of time for future scientific research.
- The bodily materials and the anonymized extraction of the medical records (containing no identifiable data) may be distributed to research projects which have been reviewed by the Netherlands Brain Bank. The research projects are conducted in the field of neurological and psychiatric diseases and normal physiological functioning of the brain.
- I understand that I can withdraw this consent at any time.

I hereby declare that:

I am not aware of any circumstances that would prevent me from acting as a representative of the donor;	☐
I am not aware of any circumstances that mean I am not allowed to register the donor at the Netherlands Brain Bank.	☐
I want to be informed about the neuropathological findings concerning the donor and understand that, if applicable, this can include information regarding a genetic disorder.	☐ **Yes** ☐ **No**
I give permission for scientific research with the donor's genome. *The genome includes the entire DNA. See the information folder, page 4, what research with the genome means.*	☐ **Yes** ☐ **No**

Name of the donor's representative _____ _____ ☐ male ☐ female

Initials _____

Relationship to the donor _____

Address _____

Postal code and city _____

Phone number _____

E-mail address _____

Place _____ Signature:

Date _____ _____

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You can ask the treating physician or general practitioner to fill in this part of the form, or leave this to the Netherlands Brain Bank. If you choose the latter option, please only fill in the name and contact information of the physician. The employees of the Netherlands Brain Bank will contact the mentioned physician. Arranging it yourself (asking the physician to sign the form) will considerably speed up the registration procedure.

TO BE FILLED IN BY THE TREATING PHYSICIAN OR GENERAL PRACTITIONER

I am the treating physician of_____*(name donor)*.

I hereby confirm that I am aware of the registration of this patient as an incompetent donor at the Netherlands Brain Bank. The patient concerned cannot be expected to independently make a decision about brain donation as a result of:

_____

(Please specify the disease(s) which have lead to incompetence).

The consequences of these disease(s) are persistent, which means that no improvement is expected on the basis of the medical prognosis of the disease.

Name treating physician _____ ☐ male ☐ female

Name hospital/nursing home, if applicable _____

Phone number _____

Place _____

Date _____

Signature:

_____

If you have any questions about the purpose and procedures of the Netherlands Brain Bank, please contact us during office hours at 020-566 5499. You can also visit our website (www.brainbank.nl / www.hersenbank.nl) or email us (secretariaatnhb@nin.knaw.nl).