BADAM BALAKRISHNA EYE BANK

Managed by : **KAKINADA EYE FOUNDATION** (Regd.No. 206/2006)
D.NO : 70-10-4, NFCL ROAD, KAKINADA – 533003.
Fax : 0884-6690567 & 2370600, Cell- 99897 99456, 94907 10666
E-Mail : badambalakrishnaeyebank@yahoo.com

CONSENT FORM FOR EYE DONATION

In order that humanity may benefit. I ________________________________
(Name and address of Person Grating Permission)

____

________________________ of ________________________
(Relationship to Deceased) (Name and address of the deceased)

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Being next of kin / kith and / or the person responsible for the burial of the deceased, hereby give to the Eye Bank My ______________ Eyes for the purpose of transplantation, therapy, medical research and /or education in accordance with
(Relationship)
practices and procedures of the Eye Bank. I also authorize the Eye Bank to obtain a complete medical history, autopsy, findings (if performed), tissue specimens and blood sample for testing necessary to insure the suitability of the tissues for transplantation purpose.

I Understand that the blood sample will be tested for HIV, HBS Ag, HCV & Syphilis before transplantation.

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Signature & Date

1) Witness : ______________________

Address ______________________

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Relationship to donor ______________________

Signature : --

2) Witness : ______________________

Address ______________________

____

Relationship to donor ______________________

Signature : --

Age of Donor : __________ **Sex :** __________

Death Date : ______________________

Time : ______________________

Cause of Death : ______________________

Retrieval Date : ______________________

Time : ______________________

Signature of the Tissue Retrieval doctor : ______________________

Name and Address : ______________________

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Medico-Legal Case

Police ______________________ ______________________ ______________________

Name & Number Signature Location