M S Ramaiah Tissue Bank

A Unit of M. S. Ramaiah Advanced Learning Centre,
Gnanagangothri Campus, Gate -4,
New BEL Road, MSRIT Post, Bangalore - 560054.
Phone : 080 -40502990, Fax- 080-23601983

RECIPIENT FORM

Recipient Name: _____

Mother's name : _____

Hospital number: _____ Sex ___ Age _____

Address

Telephone_____

Hospital Admitted in _____

Date admitted _____ Ward admitted _____

Diagnosis _____

OPERATION DETAILS:-

Date of surgery_____

Surgeon_____

Operation to be performed_____

BONE TO BE USED :

	Yes	No
Deep frozen bone	☐	☐
Irradiated deep frozen bone	☐	☐
Lyophilized bone	☐	☐
Demineralised bone	☐	☐

CORTICAL BONE ☐ ☐

LONG BONE ☐ ☐

Whole ☐ ☐

Half ☐ ☐

CANCELLOUS BONE ☐ ☐

Femoral head ☐ ☐

TKR slice ☐ ☐

Others specify

TYPE OF RECONSTRUCTION

Structural reconstruction

Filling

SOFT TISSUE TO BE USED

Patella-Ligament-Tibial Tuberosity Complex

Calcaneum-Tendon Achilles Complex

ANY OTHER REQUIREMENT HITHERTO UNSPECIFIED

I, ----------, patient / attendant do hereby give my consent to use the above mentioned allograft during my surgery. The advantages and disadvantages of using such a graft have been adequately explained to me and the associated risks such as transmission of infective diseases undetectable by present methods of testing are understood by me. I indemnify the MSR Tissue Bank since adequate measures for preventing the transmission of these and other infective diseases have been taken.

Patient's (or attendant's) Name and signature :

If attendant, relationship to patient :

Contact Number :

Requesting Doctor's Name and signature :

Hospital:

Contact Number :

For the use of MSR Tissue Bank only

Recipient Number :

Graft number and date :

Payment mode and details :

MSR Tissue Bank Officer's Name and Signature:

Date: