

University of Illinois at Chicago Multiple Sclerosis Tissue Repository

Advancing Research || Improving Treatment

PLEASE CALL, EMAIL, OR USE THIS FORM TO NOTIFY US OF ANY FUTURE CHANGES

Donor Information

If donor lives at home please continue on to section A. If not please skip to section B.

A.

Name of Donor _____

Donor's Home Address _____

City, State _____ Zip Code _____

Home telephone: (____) _____ Cell Phone: (____) _____

Office phone: (____) _____ Email: _____

Current age: _____ Date of Birth: _____

Please indicate preferred/quickest method of contact (ex. cell phone, e-mail etc):

B. Please circle if Donor lives in a Nursing/Assisted Living Facility or Hospice Program

Date of admission to facility: _____ Name of facility: _____

Address _____ City, State _____

Zip Code _____ Personal telephone: (____) _____

Contact person (at Facility): _____

Contact person phone number (____) _____

Next of Kin Information

Name _____ Relationship: _____

Home Address _____

City, State _____ Zip Code _____

Home telephone: (____) _____ Cell Phone: (____) _____

Office phone: (____) _____ Email: _____

Please provide the number where we can reach the next-of-kin for telephone consent at the time of donor's death: (____) _____

Current Physician / Neurologist _____

Address _____

City, State, Zip Code _____

Telephone (____) _____

(**If more than one change to physician information please add name, address, telephone on reverse side**)

Donor's current weight: _____ lbs. Current height: _____ feet _____ inches

For any further changes, additions, or comments, please use the reverse side of this form.

Contact Info: Phone No: (312) 996-5763 E-mail: uicmsbank@gmail.com