HÉMA-QUÉBEC

HUMAN TISSUE DONATION

Name:

Date of birth:
RAMQ number:

Form
IDENTIFICATION OF PATIENT UNDERGOING MAID ASSESSMENT

1 IDENTIFY the patient (in a health care facility or at home)

Check for exclusion criteria	YES	NO
86 years of age or more		
HIV – HBV – HCV		
Active, untreated systemic infection		
Blood cancer (lymphoma, leukemia, Hodgkin's disease, multiple myeloma)		
Alzheimer's, Parkinson's, dementia of unknown origin		
Amyotrophic lateral sclerosis, multiple sclerosis		

2 REFER the patient

Verification by the healthcare professional

☐ **MY PATIENT WISHES TO BECOME A HUMAN TISSUE DONOR UPON DEATH:**

MAID planned for: Date ____ /____ /____ Time ____ : ____ ☐ Undeterminede

My patient has already undergone cataract surgery: ☐ Yes ☐ No

☐ Health care facility: _____ ☐ At home

☐ **MY PATIENT CONSENTS TO THE SHARING OF HIS ADDRESS, PHONE NUMBER AND KNOWN MEDICAL INFORMATION WITH HÉMA-QUÉBEC:**

Phone number: ____ ____ - ____ Diagnosis motivating the MAID: _____

Best time to contact the patient (optional): Date ____ /____ /____ Time ____ : ____

3 SEND the patient's information

Fill out and send in the form

send the completed form and the medical history summary to Héma-Québec by email: **coordonnateurs.th@hema-quebec.qc.ca** or by fax **418-780-2097.**

Note: A Héma-Québec coordinator will be in touch with the patient in the 7 days prior to the planned MAID date to explain the donation process, record the patient's consent and complete a medical and social history questionnaire.

To speak with a Héma-Québec coordinator, dial 1-888-366-7338, option 2.

FOR HEALTHCARE PROFESSIONALS ONLY

Health care professional contact information:

☐ Phone: ____ ____ - ____ ☐ Fax: ____ ____ - ____

☐ Email: _____

_____ _____

Professional's name ☐ md ☐ inf. License number

_____ ____ /____ /____

Professional's signature Day Month Year

FOR HÉMA-QUÉBEC ONLY

Following assessment of the patient's eligibility for human tissue donation your patient is deemed:

☐ eligible ☐ ineligible

_____

Name of Héma-Québec coordinator

_____ ____ /____ /____

Signature Day Month Year