

To be completed in all instances where Patient wishes to remove Organ(s) / Tissues from Trust premises.

**1. Person Authorising release of organ / tissue**

Surname:	<input type="text"/>	First name:	<input type="text"/>
Position:	<input type="text"/>	Phone:	<input type="text"/>
Hospital:	<input type="text"/>	Department:	<input type="text"/>

**2. Details of Patient**

SURNAME	FORENAME	DoB	Our Ref
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Description of material for return:

**3. Nominated representative (if patient not collecting in person)**

Surname:	<input type="text"/>	First name:	<input type="text"/>
Address:	<input type="text"/>		
Phone:	<input type="text"/>	Position:	<input type="text"/>

**This is to confirm that I / we have, (tick where applicable)**

- Received the stated organ(s) / tissue / tissue blocks / slides
- Read and understood the Instructions for Safe Handling and disposal of Human Tissue and agree to abide by them (If applicable)
- Understood any clinical implications of taking this material, are not aware of any other person with an interest in the organ(s) / tissue or know of reasons why others should be consulted

Signature of patient or their nominated recipient:  Date:

Signature of authorising person:  Date:

**TO WHOM IT MAY CONCERN**

This is to certify that..... is travelling with human tissue in their possession. The tissue is appropriately contained and there is no risk associated with the transportation of this tissue stored in this manner

Person certifying the packaging of the tissue:

Name:	<input type="text"/>	Designation:	<input type="text"/>
Hospital / Department:	<input type="text"/>	Phone:	<input type="text"/>
Signature:	<input type="text"/>	Date:	<input type="text"/>