USU
Death Certificate Worksheet

Name of Deceased:____

Race:___________Gender:_________Hispanic Origin: (Y/N):_______

Legal Address:____

Address in City Limits: (Y/N): _______ Social Security Number:________________

Marital Status:____________________Date of Birth:______________

Place of Birth:_____________________Date of Death:_____________

City of Death:_______________Fathers Name:______________________________

Mothers Full Name (include maiden name) _______________________________

Veteran (Y/N, Years of Service):__________________________

Highest Level Education Completed:______________________

Occupation:______________________ Industry:__________________

Legal Informant / Relationship to Deceased:_______________________________

Legal Informant Address:____

Signature of Next of Kin, Verifying data as listed above:______________________

NOK Phone Number:_________________________

ANATOMICAL
GIFT PROGRAM

UNIFORMED SERVICES UNIVERSITY
F. EDWARD HÉBERT SCHOOL OF MEDICINE
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4712

CERTIFICATE OF BODY DONATION

UNIFORMED SERVICES UNIVERSITY

Being at least 18 years of age and of sound mind, I hereby state that it is my/the wish to donate my/the body immediately following my/the death to the Uniformed Services University of the Health Sciences for medical education, medical research, medical science as are permitted by law.

This gift shall be independent of any Will I may have and shall not be revoked by a revocation of my/the Will or by any other document unless this gift is specifically mentioned and revoked thereby. The Uniformed Services University shall not be held accountable for acting pursuant hereto unless a timely written notice of revocation by me/NOK shall have been delivered to the University upon receipt of notice of revocation, the University shall return this instrument or any copy thereof to me.

Since autopsy, embalming or organ donation other than to the University may limit the use of my body for certain medical studies, I request that only under special circumstances may these procedures be performed and then only after the prior consent of the University has been obtained. I understand that the University may, in its discretion, decline to accept this donation, and that if my body is accepted when death occurs outside a 150-mile radius of Washington, D.C., the costs of transportation must ordinarily be borne by my survivors or my estate.

It is the condition of this gift that when the anatomical studies have been completed, my body, or next of kin's body will be cremated unless other arrangements are agreed to by the University. ______________ initial (s)

______________________ DATE	______________________ SIGNATURE OF DONOR
______________________ CITY AND STATE WHERE CERTIFICATE COMPLETED	______________________ NAME (PLEASE TYPE OR PRINT CLEARLY)
______________________ STREET ADDRESS	______________________ CITY STATE ZIP

WITNESSES

______________________ SIGNATURE OF WITNESS (1)	______________________ SIGNATURE OF WITNESS (2)
______________________ NAME	______________________ NAME
______________________ CITY STATE ZIP	______________________ CITY STATE ZIP
______________________ PHONE NUMBER	______________________ PHONE NUMBER

CONSENT TO ANATOMICAL GIFT BODY TO UNIFORMED SERVICES UNIVERSITY

I, the undersigned next of kin to ________________________ do hereby consent to the DONATION of my relative following his/her death. I agree to the transfer of his/her intact body to the Uniformed Services of the Health Sciences. Next of kin, in order of priority: 1. surviving spouse, 2. adult son or daughter, 3. either parent, 4. adult brother or sister, 5. guardian, 6. other authorized person or agency as provided by law. See §4-501 et. seq., MD code Annotated.

______________________ DATE	______________________ SIGNATURE OF NEXT OF KIN
______________________ RELATIONSHIP TO DONOR	______________________ NAME (PLEASE TYPE OR PRINT CLEARLY)

Learning to Care for Those in Harm's Way

The Uniformed Services University
Anatomical Gift Program

Medical History and Research Assessment Questionnaire
SAB ID: ______________

Donor Name: ____

Person completing form: ____________________ Relationship to donor: ________________

Note: The person completing this form should answer ALL questions YES or NO, "to the best of your knowledge; comment and elaborate on all questions marked YES.

Question	Answer
1. Do you feel you know (Donor Name) well enough to answer questions regarding his/her medical and social history?	☐ Yes ☐ No
2. Weight and Height of Donor	_____Weight. _____ Height.
3. Has (he/she):	
A. Been treated by a physician in the past two years?	☐ Yes ☐ No
B. Been hospitalized in the past two years? *Why ?*_______________________________ _______________________________ _______________________________	☐ Yes ☐ No
4. Did (he/she):	
A. Have any serious illnesses or infections in the past? *What type and when?* _______________________ _______________________________ _______________________________	☐ Yes ☐ No
B. Have any surgical procedures in the past? *What type and when?* _______________________ _______________________________ _______________________________ _______________________________	☐ Yes ☐ No
5. Has (he/she) ever been diagnosed with the following contagious illnesses?	
A. HIV or AIDS	☐ Yes ☐ No
B. Hepatitis B	☐ Yes ☐ No
C. Hepatitis C	☐ Yes ☐ No
D. Tuberculosis	☐ Yes ☐ No

6. Did (he/she) ever use non-prescribed drugs, "street" drugs or other substances, e.g. cocaine, marijuana, steroids, inhalants, heroin? ☐ Yes ☐ No

*List type used, how much, when, and by what route (injected, smoked, snorted, etc).*____

7. Did (he/she) ever drink alcoholic beverages? ☐ Yes ☐ No

List type, amounts, and length used: ____

____

8. Did (he/she) ever use tobacco products? ☐ Yes ☐ No

Amount*, and length used:*____

____

9. Did (he/she) ever receive blood transfusions or blood products? ☐ Yes ☐ No

*When and why?*____

10. Was (he/she) ever refused as a blood donor or told not to donate? ☐ Yes ☐ No

*When and why?*____

11. In the past twelve months did (he/she) have any of the following?

A. Tattoo? ☐ Yes ☐ No

B. Ear / Body piercing? ☐ Yes ☐ No

C. Acupuncture? ☐ Yes ☐ No

D. Accidental needle stick? ☐ Yes ☐ No

12. Was (he/she):

A. Vaccinated or immunized for any reason in the past twelve months? ☐ Yes ☐ No

*Type and when?*____

B. Vaccinated for Hepatitis B? ☐ Yes ☐ No

13. Did (he/she) have any history of:

A. Heart disease? ☐ Yes ☐ No

B. High blood pressure? ☐ Yes ☐ No

C. Chest pain? ☐ Yes ☐ No

D. Varicose veins or poor circulation? ☐ Yes ☐ No

14. Did (he/she) have any kidney related disease(s) and/or dialysis treatments? ☐ Yes ☐ No

*Type, when, how long?*____

____

15. Did (he/she) have a history of diabetes? ☐ Yes ☐ No

Type, how long, name of medication? ____

____

16. Did (he/she) have a history of:

A. Digestive or intestinal problems? ☐ Yes ☐ No

Type, how long, treatment? ____

____

B. Bloody Stools? ☐ Yes ☐ No

C. Recent weight loss? ☐ Yes ☐ No

*How much?*____

D. Colectomy or colon recesection surgery? ☐ Yes ☐ No

17. Has (he/she) ever had cancer (including skin cancer)? ☐ Yes ☐ No

Type of Cancer: ______________________________
Number of years without recurrence? ____________________

18. Has (he/she) ever been diagnosed with any type of autoimmune disease? ☐ Yes ☐ No
Type, when diagnosed, treatment? ______________________________
____

19. Did (he/she) have a medical diagnosis of:
A. Osteoporosis? ☐ Yes ☐ No
B. Arthritis? ☐ Yes ☐ No
C. Broken Bones? ☐ Yes ☐ No
When, location of break? ______________________________

20. Did (he/she) have a history of skin infections such as leprosy, eczema, dermatitis, psoriasis, or inflammatory skin diseases? ☐ Yes ☐ No
Type, location, when, treatment? ______________________________
____

21. In the past twelve months has (he/she) ever been treated for any sexually transmitted disease such as syphilis, gonorrhea, genital herpes, or venereal warts? ☐ Yes ☐ No
Type, when, treatment? ______________________________
____

22. Has (he/she) ever been an inmate (confined to lockup, jail, or prison) for an extended period of time? *When, how long?* ______________________________ ☐ Yes ☐ No
____

Question 23 is for ONLY FEMALE DONORS

23. Has she ever had any of the following?
A. Hysterectomy ☐ Yes ☐ No
B. Tubal Ligation ☐ Yes ☐ No
C. Caesarean Section ☐ Yes ☐ No
D. Bladder Surgery of any kind? ☐ Yes ☐ No
Type______________________________

24. Did (he/she) have a history of diseases, infections, or surgeries involving the eyes such as glaucoma, cataracts, corneal disease, refractive surgery, and/or laser surgery? ☐ Yes ☐ No
Type, how long, treatment, reason for surgery? ______________________________
____

Question 25 is for POTENTIAL NEUROLOGICAL AND PSYCHIATRIC RESEARCH (Brain Tissue Studies)

25. Did (he/she) suffer from any type of neurological or brain disease such as:
For "yes" responses, provide explanation.

Condition	Yes	No
A. Alzheimer's or other dementia? ______	☐ Yes	☐ No
B. Encephalitis? ______	☐ Yes	☐ No
C. Parkinson's? ______	☐ Yes	☐ No
D. Degenerative Neurological Disease? ______	☐ Yes	☐ No
E. Multiple Sclerosis (MS)? ______	☐ Yes	☐ No
F. ALS (Lou Gehrig's Disease)? ______	☐ Yes	☐ No
G. Brain Tumor? ______	☐ Yes	☐ No
H. Seizures? ______	☐ Yes	☐ No
I. Creutzfeldt-Jakob Disease (CJD)? ______	☐ Yes	☐ No
J. Periods of confusion, memory loss or hallucinations? ______	☐ Yes	☐ No
K. Unsteady walking or visual changes? ______	☐ Yes	☐ No
L. Clinical Depression? ______	☐ Yes	☐ No
M. Bi-Polar Disorder? ______	☐ Yes	☐ No
N. Schizophrenia or psychosis? ______	☐ Yes	☐ No
O. ADD or ADHD? ______	☐ Yes	☐ No
P. Ever treated in a psychiatric facility in the past two years? *Facility name, reason, when?* ______	☐ Yes	☐ No
If (he /she) is accepted for this research would you be willing to receive a follow-up Call from the Neurological or Psychiatric Research Department?	☐ Yes	☐ No

Additional Comments (Please refer to question numbers when appropriate):

______