Stanford MEDICINE

Stanford Children's Health

STANFORD BIOBANK INTENDED DONOR INFORMATION FORM

Intended Donor Information

Name: _____

Address: _____ Phone number: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Date of Birth: _____

Neuromuscular Condition: _____ Sex: _____

Are you Hispanic/Latino (check one)? ☐ Yes ☐ No ☐ Prefer not to answer

Race (Best described, or prefer not to answer):_____

May we contact you about other studies that may be of interest to you (check one)? ☐ Yes ☐ No

Intended Donor's Next of Kin Contact Information

Name: _____

Relationship to Donor: _____

Address: _____ Phone number: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Intended Donor's Primary Physician Information

Doctor's Name: _____

Hospital/Clinic Name:_____

Address: _____ Phone number: _____

City: _____ State: _____ Zip: _____

Intended Funeral Home Information (if available)

Funeral Home Name:_____

Contact Person (if available):_____

Address: _____ Phone number: _____

City: _____ State: _____ Zip: _____