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Protocol 170957

SHILEY-MARCOS ALZHEIMER'S DISEASE RESEARCH CENTER (UCSD ADRC)East Campus Office Building 9444 Medical Center Drive, Suite#1-100 LA JOLLA, CA 92037 (858) 822-4800 (PHONE) (858) 246-1282 (FAX)

UNIVERSITY OF CALIFORNIA, SAN DIEGO 9500 GILMAN DRIVE (0948) LA JOLLA, CALIFORNIA 92093-0948

Human Research Protections Program UC San Diego			
Approved Current Approval: 04/08/2020			
Do not use after	04/25/2021		
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Consent for Autopsy

	I,, consent to having an autopsy performed on myself at the time of my death.			ıyself
	I consent to having an autopsy performed on the remains of			•
	1. Spouse	3. Parent	5. Guardian	
	2. Adult Son/Daughte	er 4. Adult Brother/Sister	□ 6	
	I understand that a complete autopsy examination may include, but need not be limited to, head eyes, spinal cord, chest, abdomen and extremities. Also included may be the removal and retention of organ(s) or tissue(s) for study, diagnosis, other scientific or therapeutic purposes, and even, when appropriate, the treatment of living patient.			d
	My consent is limited to the	following restrictions: BRAIN	ONLY	
	My consent includes an autopsy of the BRAIN, in addition to the following organs:			
	Specify additional organs (e	e.g., eyes, spinal cord):		
Partici	pant's signature	Print Name	Date/Time	
Next o	of Kin's signature	Print Name	Date/Time	

Please complete the reverse side of this form

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Please send a copy of the physician's summ	ary of the autopsy findings to			
= Trease send a copy of the physician s summi	ary of the autopsy findings to.			
Name	Name			
Ivallic	Name			
Street Address or PO Box	Street Address or PO Box			
City, State, Zip Code	City, State, Zip Code			
1	•			
AT THE TIME OF DEATH, PLEASE CALL THE UCSD ALZHEIMER'S DISEASE RESEARCH CENTER				
(858) 822-4800 – WEEKDAYS	(619) 543-6737 – AFTER HOURS AND WEEKENDS			
AFTER AUTOPSY, PLEASE CONTACT:				
(MORTUARY/SOCIETY)	TELEPHONE NUMBER			