$\texttt{BERKELEY} \bullet \texttt{DAVIS} \bullet \texttt{IRVINE} \bullet \texttt{LOS} \ \texttt{ANGELES} \bullet \ \texttt{MERCED} \bullet \ \texttt{RIVERSIDE} \bullet \ \texttt{SAN} \ \texttt{DIEGO} \bullet \ \texttt{SAN} \ \texttt{FRANCISCO}$



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

Consent for Autopsy

	I,, consent to having an autopsy performed on myself at the time of my death.				
	I consent to having an autopsy performed on the remains of I am one of the following authorized by California law to decide the disposition of the decease person's remains. In order of priority:				
	1. Spouse	3. Parent	□ 5	5. Guardian	
	2. Adult Son/Daughter	4. Adult Brother/Sister	\Box 6	5	
	eyes, spinal cord, chest, abdom	ntopsy examination may include nen and extremities. Also inclu- s) for study, diagnosis, other sci- e treatment of living patient.	ded may	y be the removal and	
	My consent is limited to the following restrictions: <u>BRAIN ONLY</u>				
	My consent includes an autops	consent includes an autopsy of the BRAIN, in addition to the following organs:			
	Specify additional organs (e.g.	, eyes, spinal cord):			
Participant's signature		Print Name		Date/Time	
Next of Kin's signature		Print Name		Date/Time	

Please complete the reverse side of this form

Version 3; December 20, 2016

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Please send a copy of the physician's summ	ary of the autopsy findings to:
Name	Name
Street Address or PO Box	Street Address or PO Box
City, State, Zip Code	City, State, Zip Code
THE UCSD ALZHEIMER'S D	OF DEATH, PLEASE CALL DISEASE RESEARCH CENTER ER'S DOCTOR ON CALL (619) 543-6737 – AFTER HOURS AND WEEKENDS
AFTER AUTOPS	SY, PLEASE CONTACT:
(MORTUARY/SOCIETY)	TELEPHONE NUMBER