English translation for reference only. The signed Dutch version is the legally valid document.

Consent Form for Brain Donation

Donor details

Surname : _____

First names : _____

Sex : male / female

Date of birth : _____ / _____ / _____

Address : _____

Postal code : _____

City / town : _____

Telephone : _____

Email (optional) : _____

General practitioner (GP) details

Name of GP : _____ male / female

Address : _____

Postal code, city : _____

Telephone number : _____

Consent

I have read and understood the information brochure "Brain donation to the 100-plus Study" about the brain tissue donation procedure. By signing this form, I consent to an autopsy being performed after my death. I agree that the biological material removed will be used for scientific research and stored indefinitely. I agree that the following tissues will be removed during this procedure.

Please tick to indicate your agreement (see explanation):

☐ Brain

☐ Skin, for establishing a cell line (optional)

☐ Cervical lymph nodes (optional)

I ☐ DO / ☐ DO NOT object to an MRI scan being performed after my death, prior to the autopsy procedure.

I ☐ DO / ☐ DO NOT object to the neuropathology report being provided to my next of kin.

☐ The 100-plus Study may request my medical records from my GP.

☐ The 100-plus Study may process my medical data and store it indefinitely for scientific research.

☐ The 100-plus Study may share my biological material and a summary of my medical data, in anonymized form, with researchers with whom a collaboration has been established.

☐ I understand that I may withdraw my consent at any time, without giving a reason.

Signature of the donor

Place: .....

Date: ..... / ..... / .....

Signature: .....

Co-signature (to be completed by a relative or loved one)

I hereby declare that I have taken note of my relative's or loved one's decision to have brain donation performed after death. I am aware of the implications of registering as a brain donor and of the procedure surrounding brain donation. I understand that, unless my relative or loved one withdraws consent, this consent will remain in effect regardless of the time that has passed since signing.

Surname : _____

First names : _____

Sex : male / female

Date of birth : _____ / _____ / _____

Relationship to the donor : _____

Address : _____

Postal code : _____

City / town : _____

Telephone (private) : _____

I ☐ DO / ☐ DO NOT wish to see the deceased after death, before transport to the hospital.

- If the deceased indicated no objection to the neuropathology report being provided to the next of kin, and you would like to be informed about it, please contact the staff of the 100-plus Study. The report will then be available from the deceased's treating physician approximately one and a half years after death. You will be notified in due course.

Signature of relative or loved one

Place: .....

Date: ..... / ..... / .....

Signature: .....