QUEENSLAND BONE BANK

Referral of Living Donor

Facility: ....

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

Please complete this form and fax to 07 3121 2633 and retain the original in the medical record

Attention: Donor Liaison Officer

Surgery details

Date of Surgery:	Hospital:

Consultant (Print name):

Site of operation: ☐ Left ☐ Right

Diagnosis:
☐ Osteoarthritis ☐ Hip dysplasia
☐ Rheumatoid arthritis ☐ Other ___________________________
☐ Avascular necrosis

Referral Source

☐ Surgeon's room ☐ Ward ☐ Preadmission clinic ☐ Theatre bookings ☐ Other

REMINDER: *Explain to the patient that the Queensland Bone Bank will phone them before their surgery to dicuss the donation process, obtain further medical information and blood tests that are required (one blood test to be done within 7 days before surgery and the other in 6 months time at no cost to the patient)*

Patient has consented to telephone contact by Queensland Bone Bank staff ☐ Yes ☐ No

Patient's home phone number:	Mobile:

Nurse / Doctor name (please print):	Signature:	Date:

Office use only (Queensland Bone Bank)

Entered into database	☐ Yes	☐ No	Histology suitable	☐ Yes	☐ No
Written consent received	☐ Yes	☐ No	Accept/decline letters printed	☐ Yes	☐ No
Auslab/Viewer check suitable	☐ Yes	☐ No	OT fax printed	☐ Yes	☐ No
QBBMS check suitable	☐ Yes	☐ No	Fax sent to OT prior to surgery	☐ Yes	☐ No
Phone interview suitable	☐ Yes	☐ No	Outcome letters sent	☐ Yes	☐ No

Notes:

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◄ DO NOT WRITE IN THIS BINDING MARGIN

V10.00 - 09/2015

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