Rocky Mountain Multiple Sclerosis Center Tissue Bank

8845 Wagner Street, Westminster, CO 80031
On Call Coordinator: 720-626-6060
(303) 788-4030 Fax: (303) 788-5418
Dr. Corboy • COMIRB # 09-0952

Donor Enrollment Information

Date: _____

Person Completing Form: [ ] Donor [ ] Next of Kin/Family Member of Donor

Name of Donor _____

Next of Kin Name _____

*If DONOR currently resides in a Nursing/Assisted Living Facility or is in a Hospice Program please provide the Name of the Institution, Addressee, Phone Number, Fax Number, and Contact Person at Facility:

_____
_____
_____
_____
_____

Type of MS **at diagnosis**

_____ Relapsing/Remitting MS

_____ Primary Progressive MS

Current type of MS

_____ Relapsing/Remitting

_____ Chronic/Secondary Progressive (if changed provide the year of change _____)

_____ Primary Progressive (if changed provide the year of change _____)

How did you hear about the Rocky Mountain MS Center Tissue Bank?

_____
_____
_____

Has any other blood relative of the donor been diagnosed with MS? Yes_____ No_____

Has the donor ever been diagnosed or suspected to have an infectious communicable disease such as Hepatitis B, Hepatitis C, HIV/AIDS, Syphilis, or Other? If yes, please provide the diagnoses, treatment given, and current status:

_____
_____

Has the donor ever had any chronic pain disorders or symptoms such as lower back pains, headaches, neuropathy, etc.? If yes, please explain the symptoms, when they started, and when, if, they have subsided:

_____
_____
_____

Has the donor been diagnosed with any other neurological disease such as Alzheimer's, Optic Neuritis, Etc.? If yes, please provide information including date of diagnosis and any current treatment pertaining to the condition:

_____
_____
_____

What were your earliest MS symptoms, in what year did they occur, how where they treated, and how soon did they stop?

_____
_____
_____
_____
_____

Do you need ambulatory assistance? Yes_____ No_____

If So, what type (circle): Cane Walker Wheelchair

Are you currently unable to walk or are bed ridden? Yes_____ No_____

Below please list the medications you have taken on a regular basis, if any, for the last 2 years:

	Name of Drug	Dosage	Dates Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			

8.

9.

10.

11.

Have you ever had a MRI of your head or spinal region? If so, where was the procedure performed, in what year was the procedure performed, and what were the results?

_____
_____
_____
_____

Did the donor ever receive any type of therapy or treatment for MS other than pharmaceuticals? If yes, please list type of therapy and year of therapy:

_____
_____
_____

Below, please list the current contact information for the donor's Primary Care Physician and Neurologist:

Primary Care Physician

Name: _____

Address: _____

City, State: _____

Telephone: (____) _____

Fax: (____) _____

Neurologist

Name: _____

Address: _____

City, State: _____

Telephone: (____) _____

Fax: (____) _____