

**MUSCULOSKELETAL TRANSPLANT FOUNDATION**

**TITLE: SUMMARY OF INVESTIGATION AND AUTOPSY - By the Medical Examiner/Pathologist**

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**I. SUMMARY OF INVESTIGATION AND AUTOPSY**

**(To be completed by the Medical Examiner/Pathologist)**

*This form **does not** constitute a release of tissue for transplantation. The information provided here is based upon review of history and information provided to the Medical Examiner/Pathologist at the time of the examination in addition to any observed physical findings noted during the pathological examination and/or supplementary test results. The Musculoskeletal Transplant Foundation also seeks history and medical information directly from next-of-kin, physicians, and other sources, as may be appropriate, in order to reach a conclusion regarding use of tissue for transplantation.*

<b><u>FINAL CAUSE OF DEATH</u></b>

_____	_____
MTF Donor NUMBER <i>or</i> Donor NAME	DATE OF DEATH

**II. Does the history or pathologic findings suggest any of the following:** **Explain 'YES' Responses**

- |                             |   |                              |       |
|-----------------------------|---|------------------------------|-------|
| <input type="checkbox"/> NO | <b>HIV infection, viral hepatitis, or other transmissible diseases</b>                                      | <input type="checkbox"/> YES | _____ |
| <input type="checkbox"/> NO | <b>Evidence of injection drug abuse or active STDs</b>  | <input type="checkbox"/> YES | _____ |
| <input type="checkbox"/> NO | <b>Infection involving the musculoskeletal system</b><br><i>(e.g., TB, osteomyelitis, etc.)</i>             | <input type="checkbox"/> YES | _____ |
| <input type="checkbox"/> NO | <b>Active systemic infection(s)</b>   | <input type="checkbox"/> YES | _____ |
| <input type="checkbox"/> NO | <b>Malignancy or hematologic disorders</b>  | <input type="checkbox"/> YES | _____ |
| <input type="checkbox"/> NO | <b>Serious autoimmune or connective tissue diseases</b><br><i>(e.g., Rheumatoid Arthritis, Lupus, etc.)</i> | <input type="checkbox"/> YES | _____ |
| <input type="checkbox"/> NO | <b>Degenerative neurologic disorders</b><br><i>(e.g., "slow viral disease", CJD, Alzheimer's, etc.)</i>     | <input type="checkbox"/> YES | _____ |
| <input type="checkbox"/> NO | <b>Other:</b> _____   | <input type="checkbox"/> YES | _____ |

**III. Have any SPECIMENS been sent for ANY of the following?**

	NO	YES	
<b>TOXICOLOGY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>If YES, results were:</b> <input type="checkbox"/> NEGATIVE <b><u>OR</u></b> <input type="checkbox"/> POSITIVE*
			<b>*If Positive, please list:</b> _____
<b>HISTOLOGY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes, results were reviewed and are reflected above.</b>
<b>NEUROPATHOLOGY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes, results were reviewed and are reflected above.</b>
<b>OTHER</b>	<input type="checkbox"/>	<input type="checkbox"/>	<i>(If yes, please list/explain)</i> _____

**IV.** **\*\*This report summarizes the findings of the Medical Examiner/Pathologist, indicating that all findings have been reviewed and that there are no PENDING or outstanding test results of this pathological examination.**

_____	_____	_____
<i>Signature</i> of ME/Pathologist	PRINT Name of ME/Pathologist	Date of Report