



PATIENT WRITTEN CONSENT

I,
 Name: _____

First Name: _____

Date of Birth: _____

Street, Zip code, City: _____

give my consent to the search for an unrelated blood stem cell donor in Germany and abroad via the Zentrales Knochenmarkspender-Register für die Bundesrepublik Deutschland gemeinnützige GmbH (ZKRD) for

- me
 my child (last name, first name) _____

I was informed in detail by the treating physician about the process and the risks of blood stem cell transplantation with an unrelated donor. I have been informed of the necessity and extent of the disclosure of my/my child's personal data in the course of a donor search.

I give my consent to the storage of my personal data/the data of my child in written and electronic form at the ZKRD within the scope of this search and the transplant coordination which potentially may follow. These data may be transferred to other participating institutions in Germany and abroad to the necessary and usual extent within the donor search and transplant coordination. Relevant accounting data may be forwarded to the affiliated organizations within the company.

The ZKRD is authorised to settle all accounts arising from the donor search and transplant coordination directly with my third party payer and to forward all required information. This includes in particular medical reports or similar information with medical confidentiality which are necessary to obtain cost coverage for the unrelated donor search. In return the payer shall be authorised to answer enquiries concerning the donor search and the transplantation and its billing, as well as to directly provide cost approvals (including documents/refund approvals) to the ZKRD.

Name of Third-Party Payer: _____

Street, Postal Code, City: _____

Insurance Number: _____

Insurance type:

- statutory health insurance private insurance subsidies/contributions others

Should the payer transfer refunded amounts to my personal account I will forward the funds to the ZKRD without delay.

 City, Date

 Signature of Patient/Guardian

For privately insured patients only: _____
 Signature of contracting party

Only a fully completed written consent can be processed!

The following declaration is **voluntary**. If the box is not ticked, this will not disadvantage you or have any implications regarding your medical treatment.

- I agree to the **one-time** mailing of informational material, including a DVD, covering the search for an unrelated donor to the above-mentioned address by the ZKRD. These items are free of charge.

Detailed information can be found on the homepage of the ZKRD under www.zkrd.de.