MUSC
Medical University of South Carolina

CARROLL A. CAMPBELL, JR. Neuropathology Laboratory

Department of Pathology and Laboratory Medicine
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Charleston, SC 29425

DONOR REGISTRATION FORM

Please email completed form to
ccnl@musc.edu

Name: _____ **Date of Birth:** _____
Last First Middle

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** _____

Email Address: _____

Place of Birth: _____ **Primary Care Physician:** _____

Race:

____ African American
____ Asian
____ Caucasian
____ Native American
____ Other: _____
____ Prefer not to answer

Ethnicity:

____ Hispanic
____ Not Hispanic
____ Prefer not to answer

Sex at Birth:

____ Female
____ Male
____ Prefer not to answer

Marital Status:

____ Single
____ Married
____ Widowed
____ Divorced
____ Separated
____ Prefer not to answer

How did you hear about us?

____ Friend ____ Speaking event ____ Physician: _____
____ Health fair/Community event ____ Google/Search engine ____ Other: _____

Veteran: ____ Yes ____ No

Branch of Service: ____ Air Force ____ Army ____ Coast Guard ____ Marines ____ Navy

Dates of Service: _____

Number of Deployments: _____

Deployment Locations: _____

Completion of this form does not obligate you to donate; you can opt out at any time. This is not a consent form.

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Please mark all diagnosed conditions:

____ Early-onset Alzheimer's disease (before 65)
____ Late-onset Alzheimer's disease (after 65)
____ Lewy body disease
____ Parkinson's disease
____ Dementia
____ Vascular dementia
____ Mixed dementia
____ Frontotemporal dementia
____ Mild cognitive impairment
____ Corticobasal degeneration
____ Amyotrophic lateral sclerosis (ALS)
____ Progressive supranuclear palsy (PSP)
____ Multiple sclerosis (MS)
____ Multiple system atrophy (MSA)
____ Huntington's disease
____ None
____ Other: _____

Please mark all symptoms present during the course of the disease(s):

____ Agitation
____ Violent outbursts
____ Delusions
____ Hallucinations
____ Depression
____ Anxiety
____ Disorientation
____ Visual problems
____ Language problems
____ Difficulty walking
____ Falls
____ Wandering
____ Stiffness
____ Tremors
____ Weight loss
____ Eating disorder
____ Sleep disorder
____ Incontinence

Please list other symptoms or personality changes noted during the course of the disease(s): _____

_____

History of head trauma: ____ Yes ____ No

If yes, please describe: _____

Next of Kin Name: _____ **Relationship:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** _____

Email Address: _____

Signature: _____ **Date:** _____

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