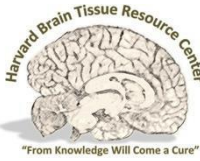




McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE



**HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL**

HARVARD BRAIN TISSUE RESOURCE CENTER (HBTRC)

Sabina Berretta, M.D., Director

Phone: 1-800-BRAIN BANK or (617) 855-2400 ♦ **Fax:** Office hours (617) 855-3199 – After hours (617) 850-8711

E-mail: Office hours HBTRC@mclean.harvard.edu - After hours HBTRCoc@mclean.harvard.edu

Website: <http://mcleanhospital.org/hbtrc/>

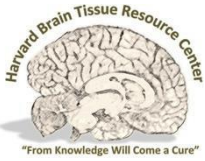
****** CONFIDENTIALITY NOTICE ******

Please note that documents you will receive from the HBTRC, pertinent to the present tissue harvesting procedure, contain confidential information belonging to the donor and their family that is legally privileged. This information is intended only for your own procedures and records. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to return or destroy the information after its stated need has been fulfilled, unless otherwise required by state law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the content of these documents is strictly prohibited. If you have received the fax in error, please notify the McLean Privacy Officer at 617-855-4860 to arrange for their destruction or return.

FOR RECORDS PROTECTED BY CONFIDENTIALITY RULES (42) CFR PART 2: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFT Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



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TISSUE RECOVERY INFORMATION SHEET
(1/2 fixed & 1/2 frozen protocol)

Pathologist Name:

Affiliation (if applicable):

Address:

Phone:

Fax:

Email:

Donor's Name:

Cause of Death:

Time of Death: A.M. P.M. EST CST MST PST **Date:**

Fresh Brain Weight: grams

Location of Recovery:

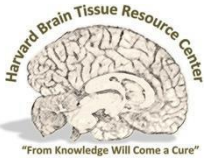
Time body was placed in refrigeration: N/A A.M. P.M. EST CST MST PST **Date:**.....

Time body was removed from refrigeration: N/A A.M. P.M. EST CST MST PST **Date:**.....

Time tissue was placed into formalin: A.M. P.M. EST CST MST PST **Date:**.....

Time tissue was frozen: A.M. P.M. EST CST MST PST **Date:**.....

YOUR GENEROUS ASSISTANCE IN PROVIDING VALUABLE TISSUE FOR RESEARCH IS VERY MUCH APPRECIATED.



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1/2 FIXED & 1/2 FROZEN TISSUE PROTOCOL INSTRUCTIONS FOR TISSUE PREPARATION, PACKAGING, & SHIPPING

1. PLEASE CALL THE BRAIN BANK AT 1-800-272-4622 BEFORE REMOVING THE BRAIN.
2. PLEASE PLACE DECEDENT INTO MORTUARY REFRIGERATION WITHIN 6 HOURS AFTER DEATH.
3. DO NOT EMBALM THE DECEDENT UNTIL AFTER THE BRAIN HAS BEEN REMOVED.
4. COMPLETE THE BRAIN REMOVAL AS SOON AS POSSIBLE AFTER DEATH
5. COMPLETE THE TISSUE RECOVERY INFORMATION SHEET PROVIDED.
6. LABEL SAMPLES WITH DONOR'S T# ID CODE.
7. THE BRAIN BANK WILL SEND THE NECESSARY SHIPPING MATERIALS TO YOUR LOCATION.

PREPARATION: BRAIN AND OTHER TISSUES:

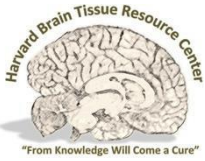
TISSUES SAMPLES TO BE COLLECTED

Brain Meninges (Dura Mater) Blood CSF Muscle Hair

1. **Blood:** Collect 2 tubes of blood in a red top tube [no additives]. Refrigerate blood.
2. **Cerebrospinal Fluid:** Collect a screw-top tube of cerebrospinal fluid. Freeze sample.
3. **Meninges (Dura Mater):** Collect the dura mater. Freezer a portion [flat] and place another portion into the formalin with 1/2 of the brain.
4. **Brain:**
 - Remove the brain including brainstem and cerebellum
 - Record whole brain weight
 - Bisect brain into right and left halves by cutting in the midsagittal plane through the corpus callosum, midbrain, cerebellum, and brainstem.
 - **Fix 1/2 Brain in 10% buffered formalin:** place the **flat, medial surface side down** toward the bottom of the plastic bucket.
 - **Freeze 1/2 Brain:** cover the brain with plastic wrap or put into a ziplock bag and place into a freezer with the **flat, medial surface side down** on a smooth flat surface.
5. **Pituitary Gland:** After removing the brain, dissect out the intact pituitary gland. Freeze sample. Place it into a labeled small plastic bag or cassette.
6. **Muscle:** Collect a small sample (equivalent to approximately 1-2 cm³) from cranial muscle. Freeze sample. Place it into a labeled small plastic bag or cassette.
7. **Hair:** Collect a few strands from the back of the head (near incision). Freeze sample. Place it into a labeled small plastic bag or cassette.



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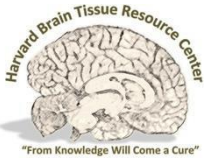
Materials List for Preparation of ½ Fixed & ½ Frozen Protocol

- 1 GALLON PLASTIC PAIL WITH LID FOR ½ FIXED SPECIMEN
- 10% BUFFERED FORMALIN (AT LEAST 0.5 GALLON)
- LARGE ZIPLOCK BAG (APPROX. 1 GAL.) TO HOLD FROZEN ½ BRAIN
- 4 SMALL ZIPLOCK BAGS AND/OR CASSETTES FOR PITUITARY, MUSCLE, HAIR, AND SKIN
- ADDITIONAL PLASTIC BAGS FOR SUPPLEMENTAL TISSUE(S) IF APPLICABLE
- 2 RED TOP TUBES [NO ADDITIVES] FOR BLOOD
- 50ML SCREW-TOP TUBE FOR CEREBROSPINAL FLUID
- 1 LARGE ZIPLOC BAG (TO HOLD DOCUMENTS INCLUDING TISSUE RECOVERY INFO SHEET)
- PERMANENT MARKER FOR LABELING

THE BRAIN BANK WILL SEND THE NECESSARY SHIPPING MATERIALS TO YOUR LOCATION AT A LATER TIME.



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SHIPMENT LABEL

Please tape label to the outside of the shipment box

The T# ID code provided by an HBTRC representative should be stated on the outside of the shipment box

**Harvard Brain Tissue Resource Center
Mailman Research Center,
Cold Room, Second Floor,
Via: Security - Admissions Building
McLean Hospital
115 Mill Street
Belmont, MA 02478-9106**

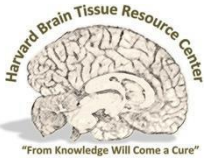
Phone: (617) 855-2400

T# _____

Please call the HBTRC when the tissue is expected to be ready for shipping. To facilitate transportation, we will need your exact location and the time the shipping box will be ready. Courier arrangements will be made to pick-up the box from the facility.



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Invoicing Instructions

Your invoice should include all of the following:

- 1) **Our case #: T-_____ (Do NOT include the donor's name on the invoice.)**
- 2) **Date of service**
- 3) **For Service: "Research Brain Removal"**
- 4) **One "All-Inclusive" Fee: \$ XXX.00 (Do NOT itemize further)**
- 5) **Complete billing address**
- 6) **Your Tax I.D. or SSN**

You can either mail your invoice to the following address:

**Harvard Brain Tissue Resource Center
McLean Hospital, MRC, Mail Stop #138
115 Mill Street,
Belmont, MA 02478**

Or email your invoice as an email attachment to HBTRC@mclean.harvard.edu
(It needs to be able to be printed as a "stand-alone" document.)

No faxed invoices please.

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