BioSight
Advancing Eye Research

Surgical Tissue Discard and Service Request Form

Contact Information

Principal Researcher's Name: _____

Contact Person: _____ **Email:** _____

Work Phone: _____ **Cell#:** _____

Surgical Tissue Discard Collection Specifications

Protocol Review (BioSight service and repository use): _____

Tissue Type/s: _____

_____

(Circle as applicable)

Main study consent: YES

BioSight Core consent: YES

Redacted clinical data: YES

BioSight Tissue Storage: YES

BioSight Tissue Pick up /Chaperoning from OR to Investigator: YES

BioSight Tissue Processing: YES

IRB protocol of reference to receive discarded human tissue and data _____

Fund code: _____

- Please notify BioSight if fund code changes.
- Please notify BioSight if you wish to STOP or HOLD receiving tissues.
- Please complete another form for multiple protocols.

_____ _____

Name of person completing this form Date