



Birth Tissue Donation Program Referral Form

- ❖ I understand that my name and contact information will remain strictly confidential and will only be used by ConnectLife for the purpose of contacting me regarding my potential participation in the birth tissue donation program.
- ❖ I authorize ConnectLife to obtain any medical records, prior to my surgery date, which may be necessary to determine my eligibility for participation in this program.

Date/Time of C-Section: _____

Obstetrician: _____

Hospital: _____

Preferred time to be reached: _____

Primary Phone #: _____

Print Name: _____

Email Address: _____

Signature: _____

Date: _____

How did you hear about the program?

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Obstetrician | <input type="checkbox"/> Facebook |
| <input type="checkbox"/> Website | <input type="checkbox"/> Twitter |
| List: _____ | <input type="checkbox"/> Other: _____ |

You will be receiving a call from phone number
(716) 529-4300 to discuss the program further and to complete all the
necessary paperwork for donation.

Please return via email to birthtissueservices@connectlife.org or fax to 716.276.3655 or return to OB/Gyn Office.

Thank you.