

Center for Parkinson's Disease & Other Movement Disorders: Personal Brain Donor Plan

Please **PRINT** all the information requested below and mail to Carol Moskowitz, 710 West 168 Street, New York NY 10032. We will call you once we receive this plan, if that is your wish.

Name _____ Date of birth _____

Social security # _____ Clinical diagnosis _____

Address _____ Next of kin _____

_____ Tele/Fax #s _____

ZIPCODE

Family doctor, address, phone & fax This person must sign the death certificate within hours

Neurologist who treats you now, address, phone & fax will provide current medical records

Neurologist who first diagnosed your movement disorder, address, phone & fax

Pathologist or assistant who follows brain protocol on www.NYBB.HS.COLUMBIA.EDU

Which neurologist has a videotape of your neurological exam? _____
If you have never had a videotaped neurological examination, please inform the neurologist who cares for you now.
We will be happy to send a videotape protocol so a complete motor exam can be recorded on videotape.

Funeral home's name, address, phone & fax. They will transport to the pathology suite

___ I have never participated in any clinical trials or other research studies.

___ I have participated in the following clinical trials:

Name of study

Doctor/nurse who ran the study

Name of study

Doctor/nurse who ran the study