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REPOSITORY Oak Ridge Operations Records Holding Area
COLLECTION Documents 1944-94
BOX No. B-139-16 Bldg 2714-H
FOLDER Misc. Correspondence file Aug 1981

ROUTING AND TRANSMITTAL SLIP

Date: August 20, 1981

TO: (Name, office symbol, room number, building, Agency/Post)	Initials	Date
1. Mr. Range		
2.		
3.		
4.		
5.		

	Action		File		Note and Return
	Approval		For Clearance	x	Per Conversation
	As Requested		For Correction		Prepare Reply
	Circulate	x	For Your Information		See Me
	Comment		Investigate		Signature
	Coordination		Justify		

REMARKS

[redacted]

File

DO NOT use this form as a RECORD of approvals, concurrences, disposals, clearances, and similar actions

FROM: (Name, org. symbol, Agency/Post)	Room No.—Bldg.
C. C. Lushbaugh	Phone No.

5041-102

OPTIONAL FORM 41 (Rev. 7-76)
Prescribed by GSA
FPMR (41 CFR) 101-11.206

☆ U. S. Government Printing Office: 1979—281-194/6

1081314

[redacted]

OAK RIDGE ASSOCIATED UNIVERSITIES
27 11 67 Oak Ridge, Tennessee

Patient Admittance Agreement

The Oak Ridge Institute of Nuclear Studies (ORINS) Medical Research Hospital is operated by Oak Ridge Associated Universities (ORAU) for the U. S. Atomic Energy Commission (AEC) for the conduct of certain clinical research programs. These programs are mainly in areas allied to the application of radiation and radioisotopes to medicine and other health sciences.

I understand that I have been accepted as a patient for admission to the hospital, or as an outpatient, because my physical condition has been determined by the hospital staff to make me a suitable patient for a currently active clinical research project.

I further understand that while a patient at the research hospital examinations, treatments, and tests may be prescribed which are experimental in nature and I hereby consent to such examinations, treatments, or tests. Notwithstanding the above, I reserve the right to a full explanation of any such proposed examination, test, or treatment and the right to withdraw my consent. I further reserve the right to withdraw completely should I find that I am unable to continue.

I further understand that I can remain in the research hospital only so long as I am needed for research purposes, and that I must be discharged when my participation in a study is completed and when, in the opinion of the hospital staff, my medical condition permits. In such event, I understand that ORAU, its officers, employees, and agents, cannot assume responsibility for any continued medical care.

The above statements have been explained to me by the member of the Medical Division staff named below. I understand and accept the statements.

I have not been influenced in making this agreement by any representations or statements regarding improvement in my physical condition or the probable results of any treatments received, but instead expressly assume all risks incident to my hospitalization, care, and treatment.

Patient's signature	Medical Division staff member's signature
[redacted]	
Parent or guardian's signature	Date

PATIENT ADMITTANCE AGREEMENT MED-13(2-67)

1081315

We understand and agree to a special experimental procedure designed to try to help our child who has acute leukemia. This will consist of removing bone marrow from the child, subjecting the marrow to radiation designed to kill the leukemic cells, and subsequently injecting these cells into the mother. At a later date it is planned to operate on the mother to drain lymph from the thoracic duct to obtain cells that can be injected back into the patient in an effort to combat the leukemia.

Since this is a new and experimental procedure, there are some risks involved for both mother and child. The nature of these has been explained to us and we are willing to accept them.

Our acceptance of this procedure is entirely voluntary. The staff of the Medical Division has put no pressure on us to agree to this, and has freely offered more conventional treatment as an alternative.

[redacted]

[redacted]

8-5-65
Date

Mildred V. Hoots, R.N.
Witness

1081316

OAK RIDGE INSTITUTE OF NUCLEAR STUDIES
MEDICAL DIVISION
OAK RIDGE, TENNESSEE

AUTHORITY TO OPERATE

(If competent, patient should sign in space indicated. If a minor or incapable of signing, representatives should sign in lower spaces.)

DATE Aug

THIS IS TO CERTIFY THAT I ☐ WE ☒ THE UNDERSIGNED, CONSENT TO THE ADMINISTRATION OF WHATEVER ANESTHETICS AND THE PERFORMING OF WHATEVER OPERATION, IN THE OPINION OF THE MEDICAL STAFF, MAY BE NECESSARY OR ADVISABLE.

[redacted]
NAME ADDRESS

EXCEPTIONS, IF ANY

WITNESS SIGNATURE OF PATIENT

PATIENT IS A MINOR ✓ ; OR STATE WHY INCAPABLE OF SIGNING

Mary E. Sutcliffe – R.N.

SIGNATURE [redacted]

1081317

OAK RIDGE INSTITUTE OF NUCLEAR STUDIES
MEDICAL DIVISION
OAK RIDGE, TENNESSEE

AUTHORITY TO OPERATE

DATE 8-22-65

(If competent, patient should sign in space indicated. If a minor or incapable of signing, representatives should sign in lower spaces.)

THIS IS TO CERTIFY THAT I [ ] THE UNDERSIGNED, CONSENT TO THE ADMINISTRATION OF WHATEVER ANESTHETICS AND THE PERFORMING OF WHATEVER OPERATION, IN THE OPINION OF THE MEDICAL STAFF, MAY BE NECESSARY OR ADVISABLE.

WE [X]

[redacted] ADDRESS

EXCEPTIONS, IF ANY

WITNESS M. Mackley R.N. SIGNATURE OF PATIENT

N. Wiseman

PATIENT IS A MINOR Yes, OR STATE WHY INCAPABLE OF SIGNING [redacted]

Parents

SIGNATURE

1081318

INSTRUCTIONS FOR RELEASE OF BODY

Body of [redacted] to be released to West [redacted] FUNERAL HOME.
(name of deceased) [redacted] Tennessee

Signed [redacted] Relationship mother Date 29 Dec 68
[redacted] father

NOTICE TO FUNERAL HOME

Mr. _____ of _____ FUNERAL HOME NOTIFIED OF
death at _____ a.m. p.m. Signed _____

Funeral Home notified Body is ready to be released at _____ a.m. p.m.

Signed _____

RELEASE OF BODY

Body of deceased released to and accepted by West FUNERAL HOME.

Signed [illegible]

Date Dec 29, 1968

1081319

CERTIFICATE OF DEATH

TENNESSEE DEPARTMENT OF PUBLIC HEALTH FILE NO.

DIVISION OF VITAL STATISTICS

THIS BECOMES A LEGAL RECORD WHEN PROPERLY EXECUTED AND FILED

TYPE OR PRINT IN PERMANENT BLUE OR BLACK INK

DECEASED — NAME: [redacted] [redacted] [redacted]

DATE OF DEATH (MONTH, DAY, YEAR): 7 December 29, 1968

DATE OF BIRTH (MONTH, DAY, YEAR): 6 March 3, 1962

RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY)): 3 White

SEX: 4 Male

AGE — LAST BIRTHDAY (YEARS): 5a 6

CITY, TOWN OR LOCATION OF DEATH: 7b Oak Ridge

INSIDE CITY LIMITS (SPECIFY YES OR NO): 7c Yes

HOSPITAL OR OTHER INSTITUTION — NAME (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER): 7d CRAU Medical Division

COUNTY OF DEATH: 7a Anderson

STATE OF BIRTH (IF NOT IN U.S.A. NAME COUNTRY): 8 Tennessee

CITIZEN OF WHAT COUNTRY: 9 U.S.A.

MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): 10

SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME): 11

SOCIAL SECURITY NUMBER: 12

USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): 13a Child

KIND OF BUSINESS OR INDUSTRY: 13b

RESIDENCE — STATE: 14a Tennessee

COUNTY: 14b Sullivan

CITY, TOWN OR LOCATION: 14c Kingsport

INSIDE CITY LIMITS (SPECIFY YES OR NO): 14d Yes

STREET AND NUMBER: 14e 3625 Memorial Blvd.

FATHER — NAME: 15 [redacted]

MOTHER — MAIDEN NAME: [redacted]

INFORMANT — NAME: 17 Parents at time of patient's admission

MAILING ADDRESS

18 PART I. DEATH WAS CAUSED BY (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), and (c))

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST

PART II. OTHER SIGNIFICANT CONDITIONS (CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a))

AUTOPSY (YES OR NO): 19a

IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH: 19b

ACCIDENT, SUICIDE, HOMICIDE OR UNDETERMINED (SPECIFY): 20a

DATE OF INJURY (MONTH, DAY, YEAR): 20b

HOUR: 20c

HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18): 20d

INJURY AT WORK (SPECIFY YES OR NO): 20e

PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY): 20f

LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE): 20g

PHYSICIAN — CERTIFICATION: I ATTENDED THE DECEASED AND DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.

SIGNATURE: [signature]

DATE SIGNED (MONTH, DAY, YEAR): 21b

MEDICAL EXAMINER — CERTIFICATION: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.

SIGNATURE: 21a

DATE SIGNED (MONTH, DAY, YEAR): 21b

CERTIFIER — NAME (TYPE OR PRINT): 21c Henry K. Speed, III, M.D.

MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 21d CRAU Medical Division, Oak Ridge, Tenn. 37830

BURIAL, CREMATION, REMOVAL (SPECIFY): 24a

DATE (MONTH, DAY, YEAR): 24b

CEMETERY OR CREMATORY — NAME: 24c

LOCATION (CITY OR TOWN, STATE): 24d

FUNERAL HOME — NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 25

REGISTRAR — SIGNATURE: 26a

DATE RECEIVED BY LOCAL REGISTRAR: 26b

ANY PHYSICIAN OR MEDICAL EXAMINER EXECUTING CERTIFICATE MUST COMPLETE AND SIGN MEDICAL CERTIFICATION WITHIN 72 HOURS. POWER OF SIGNATURE CANNOT BE DELEGATED

IF DEATH NOT ATTENDED BY PHYSICIAN, AUTHORIZED OFFICIAL SIGN HERE. PERMIT REQUIRED PRIOR TO TRANSPORTATION OF BODY BY COMMON CARRIER OR REMOVAL FROM STATE

FORM 130 REV 1-68

1081320

OAK RIDGE INSTITUTE OF NUCLEAR STUDIES
Oak Ridge, Tennessee

Request for Autopsy

NAME OF DECEASED [redacted] ROOM _____

BED NO. _____ HOSPITAL CASE NO. 511670 AGE 6 SEX MALE

MARITAL STATUS OF DECEASED IS: (Encircle word that applies)

(SINGLE) MARRIED WIDOWED SEPARATED (but not divorced) DIVORCED

TIME OF DEATH Dec (Month) 29 (Day) 1968 (Year) 0100 (Hour)

1. I hereby certify that I assume custody of the body of the above-designated deceased for purpose of burial, and assume responsibilities connected therewith.

2. I hereby authorize the Pathologist of the Oak Ridge Institute of Nuclear Studies and such person or persons as he may designate to perform an autopsy on the body of my SON
(State relationship of deceased to signer.)

I authorize him, too, to have present at that autopsy such persons as he may deem proper.

3. The autopsy here authorized may be either a complete or partial autopsy. Such organs and tissues may be removed as the physician performing the autopsy considers necessary for study subsequent to the autopsy, to accomplish the purposes of the autopsy, to eliminate undesirable radioactivity, or for therapeutic purposes. (If the nature and extent of this autopsy or the right to remove parts of the body are to be limited in any way, those LIMITATIONS SHOULD BE CLEARLY STATED BELOW). In the absence of any stated limitations, it is to be understood that the pathologist by whom the operation is performed is to be the sole judge of the nature and extent of the autopsy. He is specifically authorized to examine the cranial contents and the femur, if such examination is necessary to complete study of the case.

LIMITATIONS (Specify): LIMITED TO CHEST + ABDOMEN WITH ORGANS REPLACED AFTER EXAMINATION

4. After the autopsy, the body should be released to: WEBB FUNERAL HOME ONEIDA, TENN

5. I FURTHER CERTIFY THAT I HAVE READ AND UNDERSTAND ALL THE FOREGOING.

DATE 29 Dec 68 SIGNATURE [redacted]

ADDRESS [redacted]

[redacted], Tennessee

WITNESSES: 1. Henry K Spurlock 2. _____

Revision of March 1954.
Mod. 0139

ORAU Path # 9254

1061321

Med. 13
Rev. 1 (4-57)

OAK RIDGE INSTITUTE OF NUCLEAR STUDIES
MEDICAL DIVISION

PATIENT ADMITTANCE AGREEMENT

In consideration of my being accepted and admitted to the Research Hospital operated by the Oak Ridge Institute of Nuclear Studies, I, on behalf of myself, my heirs, executors, administrators, and assigns, convenant, understand and agree as follows:

1. To hereby release and discharge the Oak Ridge Institute of Nuclear Studies, its officers, agents, and employees from any actions, damages or claims resulting from my hospitalization in said hospital and/or any treatments and care received while in said hospital or by reason of my having been a patient therein.

2. That any treatments administered to me may be experimental.

3. That I have not been influenced in making this agreement by any representations or statements regarding improvement in my physical condition or the probable results of any treatments received, but instead expressly assume all risks incident to my hospitalization, care and treatment.

4. I understand that but for this agreement on my part, I would not be accepted and admitted as a patient in said hospital.

5. I covenant that I have carefully read the foregoing and fully understand the meaning and contents thereof, and have executed the same of my own free will and choice.

Date [illegible] 1965

Signed [redacted]
Patient Age [illegible] years

WITNESSES:

[redacted]
Father or Guardian

[redacted]
Mother

1081322

OAK RIDGE ASSOCIATED UNIVERSITIES
Oak Ridge, Tennessee

Consent to Experimental Treatment

I authorize the performance upon [redacted]
(myself or name of patient)
of the following treatment: Total Body Irradiation

(State nature of treatment)

The nature and purpose of the treatment, possible alternative methods of treatment, the risks involved, and the possibilities of complications have been explained to me. I understand that this treatment is not the usual treatment for my disorder and is therefore experimental and remains unproven by medical experience so that the consequences may be unpredictable.

DATE: 3 Dec '68 [redacted]
(Patient or person authorized to consent for patient)

WITNESS: _____

I have talked with [redacted] about
Name
the proposed course of treatment to be given [redacted]
Name
including the following:* purpose and alternatives of therapy & probable effect

C. L. Edwards 3 Dec. '68
Physician Date

*Physician should indicate experimental drugs, radioisotopes, radiation therapy, and/or possible placebo or sham therapy.

CONSENT TO EXPERIMENTAL TREATMENT MED-146(2-67)

1081323