A) Patient Details

Surname ……..…….... Forename ……..…….

Hospital ……..…….……..… Hospital Number …….……..

Date of Birth ……...

B) Collection and usage of samples

I ……..…….. (Print name) give consent for a blood sample to be taken from

……..…… (Myself or name of child) and the genetic material extracted, stored and tested for

……..…….. (Specify disorder).

Please initial the boxes below to indicate your consent

❑ The purposes for obtaining this sample and the potential implications have been explained to me and I have had an opportunity to have my questions answered.

❑ I have read and understood the information about genetic testing.

❑ It is the intention to store the sample for a maximum two year period.

❑ I understand that it may be necessary to use part of the sample anonymously for example for quality assurance or development of new tests.

Signed ……..…. Date……..
(Patient/parent/legal guardian – delete as appropriate)

C) Use and availability of results

❑ I hereby give consent for clinical and genetic information that may be relevant to other family members to be made available to relevant health care professionals.

❑ I agree to the results being entered into local or national confidential databases.

Signed ……..…. Date……..
(Patient/parent/legal guardian – delete as appropriate)

D) Person obtaining consent

I have explained to the above patient/parent/legal guardian the purpose of obtaining a sample for genetic studies and their implications.

Signed …….……..... Date……..…..

Print Name …….……. Position……..……..

Do not send this form to the Laboratory. A photocopy of the completed from should be given to the patient, the original filed in the patient's case notes and a copy filed in the family genetic record file.