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Referral form for genetic studies for inherited bleeding & thrombotic disorders: SAMPLES TO BE SENT TO St. THOMAS' HOSPITAL

Patient Details

Surname …….. Date of Birth …….

Forename …….. Hospital or NHS Number ……

Gender M / F Sample provided: Blood / Extracted DNA / Other.

Investigation requested: ……

Family Pedigree / Further information (including phenotypic levels where appropriate):

Collection and usage of samples:

Please initial the boxes below to indicate your consent

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

☐ The sample will be stored indefinitely, as required by National Guidelines.

☐ If no relevant test is currently available, I agree to the sample being stored until such time as an appropriate test is developed and the sample may then be tested.

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

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 confidential databases.

☐ I agree to the results being entered into national confidential databases

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

Person obtaining consent

I have explained to the above person the purpose of obtaining a sample for genetic studies and their implications.

Signed …….. **Date** …….

Print Name …… **Position** …….

Name of referring consultant, and address for report to be returned to.