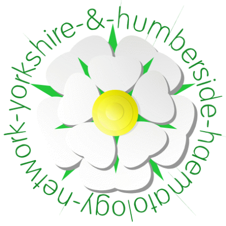

YORKSHIRE & HUMBERSIDE HAEMATOLOGY NETWORK

Study Number

CONSENT FORM

Thank you for reading the information about the Network. If you think you would like to help, please read and sign this form and either bring the completed form with you to your next clinic appointment or return it in the stamped addressed envelope provided. Please initial the boxes below if you agree with the statement:

1 I have read the attached patient information sheet (version 06, September 2009) and have been given a copy to keep. I have been able to ask questions about the project and I understand why the research is being done. ☐

2 I understand that my participation is entirely voluntary and I will not receive any payment. I am free to withdraw my consent at any time without giving a reason and without my medical treatment or legal rights being affected. ☐

3 I am willing to complete a confidential questionnaire about my background and current illness. ☐

4 I am aware that I may have already given samples for routine diagnostic purposes when I first visited the hospital clinic. I agree to these samples being stored in the long-term and used anonymously for future research projects, which may include collaboration with the pharmaceutical industry in developing new treatments. ☐

5 I give my permission for the DNA extracted from my samples to be stored and retained for use in any future research projects. ☐

6 I give my permission for a research team member to access, examine and record information from my hospital records and to store this information in the long-term for future research projects . ☐

7 I am happy for my family doctor (GP) to be informed that I am helping with this study and give my permission for a research team member to access, examine and record information from my GP records. ☐

8 I agree that any information or material that I have provided can be used for teaching purposes during which I will remain anonymous. ☐

9 I understand that all information I give will be treated confidentially and will not be used or released in such a way that I could be identified. I am aware that the data and samples will be used anonymously and so I will not receive feedback on any of the results. ☐

10 I understand that information held by the NHS and records maintained by The NHS Information Centre may be used to keep in touch with me and follow up my health status. ☐

11 I am assured that any future projects will be approved by the relevant ethics committees. ☐

12 I agree to be contacted again should any further research be considered. ☐

Name of Patient (CAPITALS)	Signature	Date
Name of Witness (CAPITALS) (If required)	Signature	Date

PLEASE RETURN THE TOP TWO COPIES OF THIS FORM IN THE ENVELOPE PROVIDED. THE YELLOW COPY IS FOR YOU TO KEEP.