



ADULT PATIENT CONSENT FORM

For further information please contact the Person Designated on 020 8909 5354

PATIENT NAME:

NHS NUMBER:

HOSPITAL NUMBER:

PATIENT D.O.B:

If you wish to participate, please complete this section by initialling the boxes and then signing at the bottom of the page.

Please initial

1. I confirm that I have read and understood the relevant information sheet, version dated, and have had sufficient opportunity to ask questions.
2. I give permission for my clinical data including my imaging from any hospitals that I have attended or will attend in the future, to be stored on a database in an anonymised format, and made available for ethically approved research, in the UK and abroad.
3. I give permission for my tissue (surplus to diagnostic requirements) from any hospitals that I have attended or will attend in the future, to be made available for ethically approved research, including genetic analysis, in the UK and abroad.
4. I give permission for my urine and/or saliva and/or buccal swab to be made available for research, including genetic analysis, in the UK and abroad.

All data and samples will be coded for anonymity.
All research projects will be approved by an ethical committee.

CONSENT FOR BLOOD DONATION

In addition to the above, we make every effort to collect blood for research while patients are having routine samples taken, or while they are under anaesthesia. Please indicate below if you agree for blood samples of up to 50ml (6-8 teaspoons) to be taken from you. You may refuse any time without giving a reason and this will not affect your medical treatment or legal rights

I wish to donate blood for research

I do not wish to donate blood for research

I understand that my participation is voluntary, and can be withdrawn at any time without giving a reason. This will not affect my medical treatment or legal rights.

Patient signature:

Print full name:

Date: / /

Staff signature:

Institution:

Print name:

Date: / /