Clinical Directorate of Laboratory Medicine, Beaumont Hospital					
Doc No:	HAEMP-LF-003	**Revision**	2	**Active Date**	30th June 2023

Beaumont Hospital Haematology
Genetic Consent

A) Patient and Sample Details (attach addressograph here)

Surname: ……..…….. Forename: ……..…….....

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

Date of Birth: ..... Requesting Consultant: ……..Bleep No: .....

Gender: Male ☐ Female ☐ Date/Time Taken: ..... Sample Type: 2mL EDTA blood sample

THIS IS TO BE KEPT IN PATIENTS CHART AND NOT SENT TO THE LABORATORY.

The responsibility for obtaining genetic consent lies with the requesting clinician.

PLEASE SEND APPROPTRIATE REQUEST FORM TO LABORATORY WITH SAMPLES.

B) Test Required (Please tick)

☐ Haemochromatosis genetic screen

☐ Factor V Leiden (APCR test required)

☐ Prothrombin Mutation

Indication for test requested:

C) Patient Genetic Consent

I give my consent for my blood sample to be sent for genetic testing. I have been given information about the testing for myself/my child. The potential implications have been explained to me and I have had an opportunity to have my questions answered. I understand that the results will be forwarded to my consultant/GP and may be used for the benefit of other family members.
I give my consent for the testing and storage of genetic material and for its use for quality assurance, development of new tests or use in anonymised studies approved by Beaumont Research Ethics Committee.

Patient Name (Print): ……**Signature:** …….....

Date: ……

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 …….…… Contact/Bleep No ……..…..

Send specimen and associated request form completed form to Haematology Department, Beaumont Hospital, Dublin 9.Tel: 01-8092703.