Consultant:
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Dr Alexander Sternberg Email: alex.sternberg@gwh.nhs.uk
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Lianne Jones Email: lianne.jones@orh.nhs.uk (Tel: 01865 572023)
Emergency/out of hours:
Clinical Haematology Ward Tel: 01865 235049

Haematology Dept.
John Radcliffe Hospital
Headington
Oxford OX3 9DU

PATIENT CONSENT FORM

Study title: Bone marrow function in normal subjects and in patients being investigated for a possible blood cell abnormality

Names of Researchers: Prof. P Vyas and Dr. A Sternberg

PART A
Please initial box if you agree

1. I confirm that I have read and understand the information sheet dated 16.07.09 (version 2.1) for the above study and have had the opportunity to ask questions ☐
2. I confirm that I am happy to give as a gift a sample of bone marrow that is surplus to that required for all the tests necessary. ☐
3. I agree for the DNA extracted from my bone marrow to be analysed ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my medical care or legal rights being affected. ☐
5. I understand that my date of birth, gender and details about my condition will be collected, stored on to a computer and accessed by medical researchers. I consent to such information being collected about me. ☐
6. I agree to take part in the study ☐

Name of patient	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

PART B*(optional)*
Please initial box if you agree

Consent for storage and use in possible future research projects

I agree that the blood, bone marrow from me and the information gathered about it can be stored by Dr Paresh Vyas at the Weatherall Institute of Molecular Medicine, John Radcliffe Hospital, Oxford, on behalf of the Medical Research Council for possible use in future projects, as described in the attached information sheet. ☐

I understand that stored samples will only be used for future studies that have been passed by a research ethics committee ☐

I understand that stored samples will not be transferred outside of the United Kingdom ☐

I understand that the sample is stored with no patient identification information. ☐

Name of patient	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

When completed, 1 for patient;1 for researcher site file; 1 (original) to be kept in medical notes