

Clinical Directorate of Laboratory Medicine, Beaumont Hospital

Doc No:	HAEMP-LF-003	Revision	1	Active Date	27 th May 2022
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**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 APPROPRIATE REQUEST FORM TO LABORATORY WITH SAMPLES.

B) Test Required (Please tick)

- | | |
|---|---|
| <input type="checkbox"/> Myeloproliferative screen
(includes JAK2 V617F and /or CALR/MPL/JAK2 exon 12) | <input type="checkbox"/> Factor V Leiden (APCR test required) |
| | <input type="checkbox"/> Prothrombin Mutation |
| | <input type="checkbox"/> Haemochromatosis genetic screen |

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

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