

CellBank Consent form

Child's initials:
 Date of birth:
 Hospital no:
 NHS no (if known):
 Clinical centre:

Thank you for reading the information about donating your/ your child's bone marrow or blood samples to CellBank for aplastic anaemia research. Please note that this is separate from any clinical trials that you/ your child may also be asked to join. If you/ your child would like to take part, please initial the boxes below if you agree. Then sign below and have this witnessed at the same time as you sign it.

- | | | |
|----------|---|--------------------------|
| 1 | I have read and understood the information leaflet (version 1, December 2018) and have been able to ask questions. These questions have been answered clearly and satisfactorily and I understand the risks and benefits of giving my/ my child's samples to CellBank. | <input type="checkbox"/> |
| 2 | I give permission for my/ my child's surplus diagnostic bone marrow, blood and other samples to be given to CellBank and for CellBank to store and give them to any researchers whose work has ethical approval and who are doing medical research on the prevention, diagnosis and / or treatment of aplastic anaemia. | <input type="checkbox"/> |
| 3 | I give permission for an additional sample of bone marrow and/or blood to be taken to be given to CellBank to store and give them to any researchers whose work has ethical approval and who are doing medical research on the prevention, diagnosis and/ or treatment of aplastic anaemia. | <input type="checkbox"/> |
| 4 | I understand how the samples will be collected, that giving samples for research is voluntary and that I am free to say no to the use of the samples at any time without giving a reason and without my/ my child's medical treatment or legal rights being affected. | <input type="checkbox"/> |
| 5 | I give permission for information about me/ my child in my/ their medical notes to be supplied to and stored by CellBank for research purposes. I understand that CellBank will keep this information confidential at all times and will only give information to researchers in a way that protects my/ my child's identity. | <input type="checkbox"/> |
| 6 | I understand that my consent can be withdrawn at any time, providing my/ my child's samples have not already been used in research. | <input type="checkbox"/> |
| 7 | I understand that neither I nor my child will personally benefit from my/my child's gift of samples. This includes my/ my child's samples being involved in research resulting in the development of a new treatment or medical test. | <input type="checkbox"/> |

Name of parent (CAPITALS)	Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of child (CAPITALS - if applicable)	Signature (if applicable)	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Person taking consent (CAPITALS)	Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Thank you for agreeing to make this gift to help research



AA Consent Form V1, December 2018