CONSENT FOR GENETIC ANALYSIS

Severe Chronic Neutropenia International Registry (SCNIR)

- ADULT PATIENT OR PARENT, FOR MINOR PATIENT -

ADDRESS:
SCN International Registry, European Office
Molecualr Haematopoiesis
Kinderklinik, Medical School Hannover
Carl-Neuberg-Str. 1
D-30625 Hanover
Phone: +49/511-557105 FAX: +49/511-557106 e-mail: SCNIR@mh-hannover.de

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Patient Identification: (Please apply patient label or write in block letters)

Surname:

First Name:

Date of Birth:

Indication for genetic analysis: _____

I hereby give consent to the genetic analysis of my/my child's peripheral blood or to investigate my/my child's from stored tissue isolated DNA with regard to genetic changes (mutations). I furthermore agree that part of this material is stored to retest relevant clinical findings in a later/further analysis.

I have been advised that with the currently available methods not all mutations can be detected. Furthermore, not all neutropenia causing genes are known. Thus, the result of this analysis may not always allow therapeutic consequences and/or prognostic statements regarding the process of this disease.

My personal details as well as all clinical findings are subject to medical confidentiality. Information related to you will be treated in strict confidence to the extent provided by law.

The patient or his/her legal guardian as well as the referring physician will be informed about all medical results in written form.

Informed consent may be revoked at anytime without any disadvantages.

_____ _____

Location/Date Signature of Patient/ Legal Guardians

THIS CONSENT DOCUMENT WAS APPROVED BY
THE ETHICS COMMITTEE OF THE MEDICAL SCHOOL HANNOVER
ON 02.06.2009