yorkshire & humberside haematology network

Consent Form

Study Number

Thank you for reading the information about YHHN.

If you think you would like to help, please read this form, **initial the statements you agree with, then sign it and either:** bring the completed form with you to your child's next clinic appointment, or return it in the stamped addressed envelope provided.

Alternatively, you can complete the form online at portal.yhhn.org

1. I have read the attached information leaflet (Version 8, July 2024) and have been given a copy to keep. I have been able to ask questions about the project and I understand why the research is being done.	
2. I understand that my/my child's participation in this study is voluntary and that I will not receive any payment. I am free to withdraw my/my child's consent at any time without giving a reason and without my/my child's medical treatment or legal rights being affected.	
3. I am willing to complete a confidential questionnaire about my/my child's background and current illness.	
4. I am aware that I/my child may have already given samples for routine diagnostic purposes when I/my child first visited the hospital clinic. I agree to these samples being stored and used anonymously for future research projects which may involve collaboration with research partners or the pharmaceutical industry.	
5. I give my permission for the cells and DNA extracted from my/my child's samples to be stored and retained for use in any future research projects.	
6. I give my permission for a research team member to access, examine and record information from my/my child's paper and computerised hospital medical records and to store this information in the long-term for future research projects.	
7. I am happy for my/my child's family doctor (GP) to be informed that I am helping with this study, and give my permission for a research team member to access, examine and record information from my/my child's GP records.	
8. I agree that any information or material I have/my child has provided can be used for teaching purposes during which I/my child will remain anonymous.	
9. I understand that all information I give will be treated confidentially and will not be used or released in such a way that I/my child could be identified. I am aware that the data and samples will be used anonymously and so I will not receive feedback on any of the results.	
10. I understand that the information held and maintained by NHS England may be used to provide information about my/my child's health status.	
11. I am assured that any future research projects will be approved by the relevant ethics committees.	
12. I agree to be contacted again should any further research be considered.	

Name of patient (Capitals)	Signature	Date
Name of parent (Capitals)	Signature	Date
Name of witness, (Capitals)	Signature	Date

Please return the top two copies of this form in the envelope provided.
The bottom copy is for you to keep.