Queen Mary University of London

Barts Health NHS Trust

CONSENT TO DONATION AND STORAGE OF TISSUE SAMPLES FOR FUTURE MEDICAL RESEARCH

Patient details (or affix pre-printed label)

Patient's full name:		Name of investigator or department:
Date of birth:	☐ Male ☐ Female	Research Ethics Committee Ref:
Hospital number (or other identifier):		Description of tissue to be taken:

Tissue collected as part of the present research project and / or procedure may be stored and used by the Barts Health NHS Trust, Queen Mary's School of Medicine and Dentistry, and approved external research organisations for future medical research.

Samples used for research may contain personal information but all such information will be anonymised at the end of any project, when the results are published, and you will not receive the results of any future research project. All staff undertaking future studies will abide by the Data Protection Act 1998 with any medical information relating to you being kept confidential. The tissue may be given to external research organisations for approved medical research but tissue will not be sold, although costs will be recovered without any financial benefit to either you or to the researcher. All tissue will be disposed of lawfully when it is no longer required.

	Patient Initials
I understand that additional tissue (described above) will be taken during my treatment / investigation and will not be used for diagnostic purposes. I agree that this additional tissue will be stored in a research tissue bank for future research.	☐
I accept that I have given my consent voluntarily to the storage of this additional tissue and that I am free to withdraw my consent at any time and the tissue to be destroyed.	☐
I agree that the tissue may be used for future genetic research but not for research that involves reproductive cloning, or be tested for inherited diseases without my express consent.	☐
I agree that my health records may be used by authorised members of staff who are not directly involved in my clinical care and my hospital number is written above.	☐

If you have any preferences or exclusions for use of the donated tissue, or any other comments, please include them here:

_____	_____	_____
Name of Patient	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature