Imperial College London

Genomic Imaging in Neonatal Encephalopathy (GENIE STUDY)

Baby's name____________________________Date of birth ☐☐ ☐☐---☐☐ ☐☐---☐☐ ☐☐

CONSENT FORMS FOR MOTHER

	Initials
1. I have been fully informed of what the study involves for me. I have read the study information sheet (version 1.1, 16/09/17) and have had the opportunity to ask questions about the project. I have received satisfactory answers to all my questions.	
2. I agree to allow a sample of my blood to be takenand used for genetic analysis for the above research study.	
3. I understand that the genetic analysis may be performed in appropriate laboratories in the UK, Europe or USA.	
4. I give permission for my medical and electronic health records to be looked at and analysed in strict confidence by responsible individuals from the research team or the NHS Trust.	
5. I understand that participation in this project is voluntary and that I am free to withdraw my participation at any time, without giving a reason and withoutaffecting my medical care or legal rights.	
6. I understand that I will not receive specific results or feedback about my blood sample.	
7. I agree for my information and the blood sample I have donated for this study to be stored on a long---term basis at Imperial College London for use in future Research Ethics Committee approved research. I understand that the information and genetic data will be held securely and confidentially	
8. I understand that very occasionally a genetic risk factor may be identified that may have important implications for my future health. In these rare circumstances, the researchers will take advice from a clinical geneticist who may recommend that I and my GP are contacted to offer me the opportunity to seek further advice through a specialist genetic counselling service.	**Please initial only one box below**
I wish to be contacted about any findings that may have important implications for my future health.	
I **do not** wish to be contacted about any findings that may have important implications for my future health.	

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Name of parent Signature Date

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Name of person taking consent Signature Date

Imperial College London

CONSENT FORMS FOR FATHER

	Initials
1. I have been fully informed of what the study involves for me. I have read the study information sheet (version 1.1, 16/09/17) and have had the opportunity to ask questions about the project. I have received satisfactory answers to all my questions.	
2. I agree to allow a sample of my blood to be taken and used for genetic analysis for the above research study.	
3. I understand that the genetic analysis may be performed in appropriate laboratories in the UK, Europe or USA.	
4. I give permission for my medical and electronic health records to be looked at and analysed in strict confidence by responsible individuals from the research team or the NHS Trust.	
5. I understand that participation in this project is voluntary and that I am free to withdraw my participation at any time, without giving a reason and without affecting my medical care or legal rights.	
6. I understand that I will not receive specific results or feedback about my blood sample.	
7. I agree for my information and the blood sample I have donated for this study to be stored on a long---term basis at Imperial College London for use in future Research Ethics Committee approved research. I understand that the information and genetic data will be held securely and confidentially	
8. I understand that very occasionally a genetic risk factor may be identified that may have important implications for my future health. In these rare circumstances, the researchers will take advice from a clinical geneticist who may recommend that I and my GP are contacted to offer me the opportunity to seek further advice through a specialist genetic counselling service.	**Please initial only one box below**
I wish to be contacted about any findings that may have important implications for my future health.	
I **do not** wish to be contacted about any findings that may have important implications for my future health.	

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Name of parent Signature Date

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Name of person taking consent Signature Date