South Eastern Sydney Local Health District

Facility:

Draft 2

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

HEALTH PRECINCTS BIOBANK CONSENT

Consent for Health Precincts BIOBANK

- I _____ agree to participate in the Health Precincts Biobank described in the patient information brochure provided.

Or *(if applicable)*

- I_____ as guardian/power of attorney for _____ agree for their participation in the Health Precincts Biobank described in the patient information brochure provided.
- I have read the patient information brochure or have had it read to me in my first language, and I understand it.
- I have been given the opportunity to ask any questions and I have received satisfactory answers.
- I understand that I can withdraw consent at any time without affecting any medical treatment or care now or in the future.
- I agree that research data gathered from the results of the Biobank may be published, provided that I cannot be identified.
- I understand that if I have any questions relating to my participation I can contact the Health Precincts Biobank directly using the contact details provided in the patient information brochure.
- I acknowledge receipt of a copy of the patient information brochure for my own records.

Please read carefully and tick either YES or NO.

1. I give my permission for the collection of tissue/fluid and blood/saliva samples and their use in future research. Yes ☐ No ☐
2. I give my permission for the collection of clinical hospital data, the linkage of data from other sources and its use in future research. Yes ☐ No ☐
3. I give permission to Services Australia to provide my/the participant's Medicare and/or Pharmaceutical Benefits Scheme periods (PBS) claims history for the period 1/11/2009 to 31/12/2033 for the Health Precincts Biobank study. Yes ☐ No ☐

Medicare Card Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ /___

- A copy of this consent form will be sent to Services Australia
- Additional information about Medicare/PBS claims history will be provided to you, or can be found on the Health Precincts Biobank website.

PARTICIPANT PRINT NAME	SIGNATURE	Date
GUARDIAN/POWER OF ATTORNEY NAME (if applicable)	SIGNATURE	Date

Original - Health Precincts Biobank Copy - Medical Record

SES020063

Holes punched as per AS2828-2012

BINDING MARGIN - NO WRITING

HEALTH PRECINCTS BIOBANK CONSENT

SES020.063

S0632 230522

NO WRITING

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