



Consent for Genomic Medicine Testing

Name:
HN: Date:
Birth Date: Age:
Room: Sex:
Physician:
Allergies:

Consent for Genomic Medicine Testing

(Hospital Copy)

Date.....

By this consent, I, Mr. / Mrs. /Ms.....Age.....Year

NationalityA holder of passport number.....

Date of issue.....Date of expiration.....

Residing at No.....Moo.....Soi.....Road.....

Sub-district.....District.....Province.....

Postcode.....Telephone number

I consent to participate in genomic medicine testing from Bumrungrad Hospital Company Limited

License number 10201010462 Located at 33 Sukhumvit 3 (Soi Nana Nua), Wattana, Bangkok 10110 Thailand (“Hospital”)

Telephone number +66 2066 8888 Name of physician/genetic counselor.....

Medical license number/License number.....

I have already acknowledged completely information about the genomic medicine from physician, public healthcare professional or hospital staff, therefore, I acknowledge and consent to the following:

- 1. To perform medical procedure to analyze, diagnostic and recommend medication used for medical care, disease prognosis, disease risk assessment, and its prevention by using the science or technology of genetics at the molecular level.
- 2. To follow-up the results of the genomic medicine testing at this time.
- 3. To allow the Hospital to retain my genetic information and data for 5 years from the date I received services. If the said period has elapsed, I consent the hospital to withdraw the collection of my genetic information which I have been informed by hospital already.

In this regard, I have been explained by assigned physician, public health professionals or hospital’s staff about the steps and processes of providing services, purpose of data collection as well as the complication of medical care services.



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Allergies:
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(Hospital Copy)

Signature
Witness 1
Signature
Witness 2
Date
Time
(Physician/Genetic counselor)
(Fingerprint/consent over telephone)

Interpreter's Statement

I have given a translation of Consent for Genomic Medicine Testing that the physician/healthcare professional has explained to patient/patient's representative.

Translate to Language
Interpreter

Status of Signer (According to Thai Civil and Commercial Code)

- checkbox Patient, who is 20 years old or above, and capable of giving consent
checkbox Spouse in case that the patient is not capable of giving consent (unconscious)
checkbox Holder of parental responsibility in case that the patient is minor (under 20 years old)
checkbox Curator in case that the patient is quasi incompetent person (adjudged by the court)
checkbox Guardian in case that the patient is incompetent person (adjudged by the court)

Please attach the following supporting documents:

- 1. A copy of your national identification card/passport/driver's license, government official card, or any other ID card issued by the government in which your photo is attached, with a certified true copy (for the patient).
2. A copy of documents proving the relationship as a father, mother, spouse, child, adopted child, or sibling of the patient, such as a marriage certificate, house registration, birth certificate, custody certificate (in case the parents are not married), adoption registration certificate, or other government-issued documents, on which the information regarding religion and blood type appeared (if any) is redacted, with a certified true copy.

Relationship with the patient
Identification number of the patient's representative
Telephone number
Email



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Physician:
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Relationship with the patient
Identification number of the patient's representative
Telephone number
Email