

Lab Use Only

Res Lab #: \_\_\_\_\_

Date Rec'd: \_\_\_\_\_

Initials: \_\_\_\_\_

**National Inherited Bleeding Disorder  
Genotyping Laboratory**

Department of Pathology and Molecular Medicine  
Queen's University, Kingston, Ontario



**Hemophilia A and B Genotype Testing Requisition**

**Patient Name:** John Doe Male  Female   
(Surname, First Name)

**DOB:** 2010 / 01 / 01 **Unique Identifier:** 0000-000-000-AA  
YY MM DD eg. Health card #, Hospital #

**Date of specimen collection:** 2016/01/01 **Phlebotomist:** A. Phlebotomist  
YY MM DD

**Referring Clinic:** Canadian Hospital **Report to:** AHCDC Member

**Test Requested:** Hemophilia A  Hemophilia B

**Coagulation Factor Level:** Factor VIII 0.1 U/mL Factor IX \_\_\_\_\_ U/mL

**Inhibitor:** Yes  No  **Inhibitor Titre:** \_\_\_\_\_ B.U.

**Has intron 22 inversion testing been done?** Yes  No

**Information Requested:**  Confirmation of diagnosis  
 Carrier status  
 Prenatal diagnosis

Have samples from this family been sent to this lab before? Yes  No

If Yes, specify \_\_\_\_\_

Relationship to this patient \_\_\_\_\_

**Sample Requirements:**

6 cc whole blood  
EDTA (lavender top) or  
ACD (yellow top) or  
DNA

**Ship to:**

**Attn: Jayne Leggo**  
Department of Pathology and Molecular Medicine  
Queen's University, Richardson Laboratory, Room 201  
88 Stuart St., Kingston, Ontario K7L 3N6  
Tel: 613-533-3187 FAX: 613-533-2907  
Email: nphmt@clinlabs.path.queensu.ca

November 24, 2015

**Voluntary Nature of Participation**

Your participation is voluntary. If you do not wish your sample to be used for research this will have no impact/effect on your current or future health care. Additionally, you may withdraw at any time and your withdrawal will not affect you or your families' future medical care with your Hematologist or at this hospital.

**Consent**

I have read and understand the consent form for this research. I acknowledge that the purpose of storing my samples for future research has been explained to me and that any questions that we have asked have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

By signing this consent form, I do not waive my legal rights nor release the investigator(s) and sponsors from their legal and professional responsibilities.

I give permission to the Genotyping Lab to obtain my (or my child's/ward's) sample from KGH (if applicable)

Jann Doe  
Name of Patient (print)

FHCDC Member  
Name of person obtaining consent (print)

Mrs Jane Doe  
Name of Person giving consent

FHCDC Member  
Signature

Mother  
Relationship to Patient

Jan 1 / 2016  
Date

Jane Doe  
Signature

I agree that the study investigators can store my (or my child's/ward's) sample(s) for use in future research on inherited bleeding disorders.

YES

NO

JD / Jan 1 / 2016  
Initials Date

If you have any questions about the research you may contact:

Dr. David Lillicrap  
Department of Pathology  
Rm 202, Richardson Laboratory  
Queen's University  
Kingston, ON, K7L 3N6  
Tel: (613) 548-1304

OR

Dr. Lois Shepherd, Head  
Department of Pathology  
Rm 202, Richardson Laboratory  
Queen's University  
Kingston, ON, K7L 3N6  
Tel: (613) 533-2850

If you have any questions about your rights as a research participant, you may contact:

Dr. Albert Clark  
Chair, Research Ethics Board  
Queen's University Health Sciences and Affiliated Teaching Hospitals  
Office of Research Services  
Fleming Hall, Jemmett Wing  
Queen's University  
Kingston, ON K7L 3N6  
Tel: (613) 533-6081

November 24, 2015

**Children's Assent Form: Molecular Hemostasis Laboratory-Genotyping Research**

I understand that I am being tested for an inherited bleeding disorder. This means that Doctor AHCDK Membe has explained to me that this is being done to help understand the effects this disease has, or might have, on me.

I understand that it is up to me whether I want my sample to be used in research or not and that it is OK if I decide I do not want to. I also understand that even if I agree today I can change my mind later.

I understand that while the research may not help me directly, it may help other people with the same disease.

I have had a chance to think about my sample being used in research, and have had my questions answered. If I think of any questions in the future, I can discuss them with Drs. Lillcrap and/or James.

I understand that all of the information that is discovered from this research will be kept private.

I agree to be my sample being used for research.

John Doe  
Name of Child

John Doe  
Signature of Child

Jan 1 / 2016  
Date

Mame Doe  
Signature of Parent/Guardian

Jan 1 / 2016  
Date