Bumrungrad International HOSPITAL

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

Nationality .....A 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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Birth Date: ..... **Age**: .....

Room: ..... **Sex**: .....

Physician: .....

Allergies: .....

(Hospital Copy)

Signature……..……..……..…….. Witness 1 ……..……..……..……..

(.....) (.....)

Signature……..……..……..…….. Witness 2 ……..……..……..……..

(.....) (.....)

(Physician/Genetic counselor) (Fingerprint/consent over telephone)

…….....……..…..…… ……..

Date Time

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 ……..……..……..……..

(.....)

Bumrungrad International HOSPITAL

Consent for Genomic Medicine Testing

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HN: ..... **Date**: .....

Birth Date: ..... **Age**: .....

Room: ..... **Sex**: .....

Physician: .....

Allergies: .....

(Hospital Copy)

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

- ☐ Patient, who is 20 years old or above, and capable of giving consent
- ☐ Holder of parental responsibility in case that the patient is minor (under 20 years old)
- ☐ Legal spouse in case that the patient is not capable of giving consent
- ☐ Curator, a person appointed by the court to take care of a patient who is a quasi-incompetent person
- ☐ Guardian, a person appointed by the court to take care of a patient who is an incompetent person
- ☐ Authorized representative acting on behalf of the patient in case that the patient is not capable of giving consent

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.
3. A court order appointing the Curator, certified by the court, together with certified true copy of the Curator's ID card, and any document specifying the scope of authority (if applicable).
4. A court order appointing the Guardian, certified by the court, together with certified true copy of the Guardian's ID.
5. A Power of Attorney from the patient or from the legally authorized person, together with certified true copies of the ID cards of both the grantor and the authorized representative, in accordance with the procedures of the healthcare facility.

Relationship with the patient……

Identification number of the patient's representative……

Telephone number……

Email……

Bumrungrad International HOSPITAL

Consent for Genomic Medicine Testing

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Allergies: .....

Consent for Genomic Medicine Testing

(Patient Copy)

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(Patient Copy)

Signature……..……..……..…….. Witness 1 ……..……..……..……..

(.....) (.....)

Signature……..……..……..…….. Witness 2 ……..……..……..……..

(.....) (.....)

(Physician/Genetic counselor) (Fingerprint/consent over telephone)

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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.
3. A court order appointing the Curator, certified by the court, together with certified true copy of the Curator's ID card, and any document specifying the scope of authority (if applicable).
4. A court order appointing the Guardian, certified by the court, together with certified true copy of the Guardian's ID.
5. A Power of Attorney from the patient or from the legally authorized person, together with certified true copies of the ID cards of both the grantor and the authorized representative, in accordance with the procedures of the healthcare facility.

Relationship with the patient……

Identification number of the patient's representative……

Telephone number……

Email……