



Polycystic Kidney Disease Tissue Donation Consent Form

I, _____, wish to make an anatomical gift of residual tissue from elective surgery for use in medical research. I authorize my physician and medical facility to release tissue of no clinical value secondary to the surgical procedure and to ship the tissue to a research institution. I consent to have my physician and hospital staff involved in the case provide the necessary information to the PKD Foundation in order to make arrangements for the donated tissue to be transported to the research facility. I understand that no personal identifiers will be provided to the investigator and I will not be contacted by the research facility.

About Whole Genome Sequencing

Some studies may look at many genes by studying all of your DNA. This type of study is called “whole genome sequencing.” Your genes tell a genetic story about you, like reading words in a book. Sequencing your whole genome is like reviewing your story, word by word, one letter at a time to look for spelling differences. By looking at the whole DNA of lots of patients, researchers can find which genes may impact a disease and perhaps identify new treatments. Any scientists that work with your DNA will be prohibited from using the results to identify you.

Your individual genomic data and health information may be put in a protected data repository. This repository is restricted to researchers who apply for and get permission to use the genetic information for a specific research project. Your genomic data and health information will not be labeled with your name or any other identifying information. Researchers approved to access information in the repository must agree not to attempt to identify you.

The investigator will be provided non-identifying information such as my gender and age, date of surgery, surgeon’s name and laboratory test results.

Please return via email to research@pkdcure.org.



Procedure: _____

Date of surgery: _____

Physician(s): _____

I give permission for donation of the following tissues: _____

Signature

Print name

Hospital Name and Address

Home Mailing Address

Witness Signature

Witness Signature

Witness Print

Witness Print

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