

# PARTICIPANT INFORMED CONSENT FORM

## (Screening for Thalassaemia / Sickle cell Anaemia)

**Study Title :** Screening and Counselling of Genetic Disorders: Incorporating Prevention of Genetic Disorders in Maternal & Child Health Program.

**Name & Affiliation of Principal Investigator (s)**

Director, Institute of Genetics & Hospital for Genetic Diseases

The contents of the information sheet that was provided have been read carefully by me / explained in detail to me, in a language that I comprehend, and I have fully understood the contents. I confirm that I have had the opportunity to ask questions. The nature and purpose of the programme and other relevant details have been explained to me in detail. I understand that my decision regarding my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal right being affected. I understand that the information collected about my participation in this program will be kept confidential. I am willing to participate in this program.

I agree to enrol myself in the above program.

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(Signatures / Left Thumb Impression) Place:

Date:

Name of the Participant: \_\_\_\_\_

Son / Daughter / Spouse of: \_\_\_\_\_

Complete postal address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature of Witness

Date: