

CONTROL CONSENT

PERSONAL INFORMATION					
Date: / /	Donor ID code:				
Family name:	First name:				
DOB:	Gender:	Male	Female (please circle)		
Contact Details: Address					
Phone (daytime contact)					
CONSENT FORM					
I,, consent to Services. I understand that my blood sample m					
☐ Lymphocyte and Neutrophil Function tes	sts				
☐ PFA 100					
☐ Platelet Function Test					
☐ Miscellaneous eg trial					
When the tests are completed, should there be a up by a doctor, I would prefer:	any clinically s	ignificar	nt finding that requires follow		
☐ The results to be given to the relevant R	CH Pathologis	st who w	vill discuss them with me.		
The results with a letter of explanation to contact me.	be sent to a s	specified	Doctor who will then		
The name of my Doctor to send results to:					
Name:					
Phone Number:					
I have had this procedure explained to me and I P-027):	have read the	Contro	I Information Statement (LS-		
Signature:					
Date:					

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Authorised by: D. Tucker	Reference:LS-F-032	Page 1 of 1