Krebsprädispositionssyndrom-Register 01

Registerleitung:
Prof. Dr. med. Christian Kratz
Prof. Dr. med. Stefan Pfister

Prof. Dr. med. Christian Kratz
Klinik für Pädiatrische Hämatologie und Onkologie der MHH
Telefon: 0511 532-6711
Fax: 0155 532-169020
E-Mail: kratz.christian@mh-hannover.de
Carl-Neuberg-Straße 1, 30625 Hannover

Prof. Dr. med. Stefan Pfister
Hopp-Kindertumorzentrum Heidelberg
Pädiatrische Neuroonkologie, DKFZ
Telefon: 06221 42-4617
Fax: 06221 42-4639
E-Mail: s.pfister@dkfz.de
Im Neuenheimer Feld 580, 69120 Heidelberg

Informed Consent for patients 12-17 years of age

ADDRess as a part of

Cancer-Predisposition-Syndrome-Registry-01

Surname, first name of the patient _____ Date of birth _____

Treating hospital _____

I agree that information about my illness as well as blood, bone marrow, skin and cheek mucosa as described in the information form, may be passed on to the ADDRess project as a part of CPS-R01 so that research can be conducted on my illness. The aim of the research is to learn more about the disease in the long term. With the knowledge gained in this way, it should be possible to treat those affected better in the future.

The study was explained to me personally and I read the information form. I had the opportunity to ask questions. I know that my participation is voluntary and that I can withdraw my consent at any time without giving reasons and without any disadvantages. I understand that I will be contacted again as soon as I am 18 years old so that I can then decide whether I want to continue participating in the study.

CONFIRMATION OF THE PARTICIPANT

Surname, first name of the patient

Place, date

Signature of the patient

CONFIRMATION OF THE ATTENDING PHYSICIAN

I have discussed the CPS-Registry-01 and the accompanying research including the patient information and the declaration of consent with the patient. All questions were answered comprehensively. I explained to the participant that participation is voluntary. I have obtained the patient's consent.

Name of physician

Place, date

Signature of physician