



Dipartimento Interaziendale Materno Infantile
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Struttura Semplice Dipartimentale di Genetica Clinica
Responsabile: Dr.ssa Livia Garavelli

Attachment 04 – INFORMED CONSENT FOR RESEARCH

Version n. 1 22/02/2018

Project title: Expanding phenotype of Wiedemann-Steiner Syndrome: C2-C3 vertebral fusion.

Principal Investigator: Livia Garavelli

By signing this consent form, you confirm that you have been informed verbally and through the Information Sheet relating to the aforementioned study. You hereby confirm that you have read and understood the Information Sheet of the study, that you confirm that you are voluntarily giving your consent for the participation of your son/daughter in the study, and that you were allowed to ask the investigator and/or your doctor any pertinent questions.

Furthermore, you confirm that the information you received was complete and that you were allowed to decide freely to have your son/daughter participate in the study.

You have the right to withdraw your son/daughter at any time without any consequences for him/her. A copy of this consent will be given to you once it has been completed.

Surname:

First Name:

Date of Birth:

Signature:

If the participant is a minor:

Signature of the parents or legal guardian:

Relationship with the participant:

Signature for the minor's acceptance (if applicable):

Optional information for the family doctor:

I agree

I disagree

to inform my family doctor of my son's/daughter's participation in the study

Place and date:

CASE DOCTOR

By signing below you confirm that you have supplied your patient (or your patient's parents or legal guardian) all the appropriate information regarding this study and that you have replied to all the questions that you were asked.

Surname:

First Name:

Signature:

Place and date:

Doctor's stamp:

PRINCIPAL INVESTIGATOR:

Place and date:

Telephone number:

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