**.................. PROVINCE**
**.................................. FAMILY PRACTICE UNIT**

## PRE-MARITAL SMA/HAEMOGLOBINOPATHY SCREENING REFERRAL CONSENT FORM

We applied to the family practice unit to obtain a Pre-Marital Health Report and gave a blood sample. As a result of the examination, we were informed about the results of our carrier status (carrier, suspect). We were informed about haemoglobinopathies / SMA, one of the inherited blood diseases, and its possible consequences. We were told that we should go to a haematology specialist / internal medicine specialist / medical genetics specialist in order to have further examinations related to the disease and to have a healthy baby with the necessary treatments. It was stated that we should have advanced diagnostic examinations related to the disease and receive genetic counselling from a medical geneticist.

We accept and undertake that if we fail to go to the relevant specialist or do not comply with the follow-up and treatments recommended by the specialist, we will bear all responsibility and we will not file a civil and criminal lawsuit against any person, institution and organisation in charge.

**FEMALE SPOUSE / PROSPECTIVE SPOUSE**

First-Last Name :

TR ID No :

Telephone :

Address :

...../...../…...

Signature.....................................

**MALE SPOUSE / PROSPECTIVE SPOUSE**

First-Last Name :

TR ID No :

Telephone :

Address :

...../...../…...

Signature...................................

The person/persons whose identity information is written above have been informed about SMA/Hemoglobinopathy diseases and screening results and the procedures to be performed hereafter, and this signed consent has been notified to them.

**CONSULTED BY**

First-Last Name :

...../...../…...

Signature.....................................

**APPROVED BY**

First-Last Name :

...../...../…...

Signature...................................