CONSENT FORM FOR BACTERIOPHAGE SENSITIVITY TESTING

Patient Details:

1. Name: ____
2. Gender: ________________________________
3. Date of birth (DD/MM/YY): ____/____/________
4. Condition(s): ____
5. Sample(s) given for bacteriophage sensitivity testing: ________________________________

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6. Date sample(s) given (DD/MM/YY): ____/____/________

I have voluntarily opted for giving the Sample(s) to Dr Dang's Lab to conduct bacteriophage sensitivity testing for the Condition(s).

I understand that bacteriophage sensitivity can only be performed if there is growth of organism(s) detected in the sample sent to the lab.

I understand that the laboratory has standard bacteriophage preparations for a certain set of bacteria. If growth of any other bacteria is detected, against which the standard bacteriophage preparations cannot be tested, the isolate may have to be sent to the Eliava Phage Therapy Center.

I understand that this bacteriophage sensitivity testing is made possible by Vitalis Phage Therapy in collaboration with the Dr Dang's Lab. I voluntarily agree to Dr Dang's Lab sharing the information contained in this form as well as the results of the culture testing of the sample(s), and bacteriophage sensitivity testing conducted as per this form with Vitalis Phage Therapy, for the sole purpose of sharing the details with the Eliava Phage Therapy Center, for the potential treatment of the Condition.

I understand and agree that Vitalis Phage Therapy and/or Eliava Phage Therapy Center may contact me for the purposes of treating the Condition by Eliava Phage Therapy Center.

I have read the contents of this form/ have been explained to me in and I have fully understood them. I am voluntarily consenting to contents of this form by appending my signature below being in a competent, sound, able and capable mind and condition and without there being any coercion, undue-influence, mistake, misrepresentation or fraud.

Signature: ___________________________ Date (DD/MM/YY): ____/____/________

Important – In case of a minor / unsound / incompetent patient, the guardian and / or parent would be required to sign this form on the patient's behalf.

Name of Guardian / Parent: ____

Signature: ___________________________ Date (DD/MM/YY): ____/____/________