



How you want to be treated.

St Paul's Hospital Laboratory
1081 Burrard Street,
Vancouver BC, V6Z 1Y6
604-806-8810-ext 63665

PSA Testing - Consent Mineral Exploration Roundup 2011 January 25 & 26, 2011

The Prostate Specific Antigen (PSA) test is a screening test for prostate disease. A blood sample will be taken from your arm for your PSA level to be tested at St Paul's Hospital. The results will be sent directly to your family doctor. You must contact him/her to discuss the results. If you do not have a family doctor, we are unable to do the test for you today. Please complete the following consent form. Your personal information is held in strict confidence.

Print your name and address

Name	Date of birth (D/M/Y)
Address	Phone

Print your family doctor's name and address

Doctor's Name	Physician # (BC only)
Doctor's Address	Phone
	Fax

Consent

I have read the British Columbia Cancer Agency brochure - "*The Pros and Cons of PSA Screening for Prostate Cancer*".

- I have talked with my family doctor about PSA testing. **or** I wish to take the test before I talk with my family doctor.

I agree to have St Paul's Hospital Laboratory staff collect my blood by venipuncture to test for PSA. This is at no cost to my medical services plan or to me. I have been given an opportunity to ask questions about the risks involved in having blood taken and I have had all of my questions answered thoroughly and to my satisfaction.

Governing Law: I agree that the relationship and the resolution of any and all disputes arising between myself and my family doctor, and between myself and Providence Health Care, its directors, officers, agents, and employees, shall be governed and construed in accordance with the laws of the Province of British Columbia.

Jurisdiction: I acknowledge that the blood collection and testing is performed in the Province of British Columbia and that the Courts of the Province of British Columbia have jurisdiction to entertain any complaint, demand claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. I agree that if I start any such legal proceedings they will be only in the Province of British Columbia, and I submit to the exclusive jurisdiction of the courts of British Columbia.

Your signature below indicates that you have read this document and you agree to these terms. An extra copy of this form is provided for your records.

Participant's Signature _____ Please print name _____ Date _____

Witness' Signature _____ Please print name _____ Date _____

Please give this signed consent form to our staff at the time of blood collection.

For Lab Use

Reviewed by _____ Collected by _____ Date / time _____