Division of Genome Diagnostics
at BC Children's and BC Women's Hospitals
4500 Oak Street, Vancouver B.C. V6H 3N1
Cytogenetics Tel: 604-875-2304, Fax: 604-875-3601
Molecular Genetics Tel: 604-875-2852, Fax: 604-875-2707
www.genebc.ca

Directive to Destroy Residual DNA Form

Patient & Sample Information

DNA from: ☐ Blood ☐ Amniocytes ☐ Chorionic Villi ☐ Other _____

Last Name	First and Middle Names
Date of Birth (DD/MMM/YY)	Provincial Health Number
Date Sample Collected (DD/MMM/YY)	

Requestor Information

Relationship to Patient & Sample:

☐ Self

I,_____, hereby request the Division of Genome Diagnostics destroy my residual DNA sample. If clinical testing is not complete, the sample should be destroyed following completion of testing.

I understand that by making this request, residual DNA will not be available should any quality control / assurance be required in follow up to the clinical testing performed.

_____
Name

_____
Date (DD/MMM/YY)

_____
Signature

☐ Parent(s)/legal guardian(s)
(Both parents must sign, unless they attest to being the only parent/legal guardian.)

We/I,_____and_____, parent(s) or legal guardian(s) of the child described above, hereby request the Division of Genome Diagnostics destroy our/my child's residual DNA sample. If clinical testing is not complete, the sample should be destroyed following completion of testing.

We/I understand that by making this request, residual DNA will not be available should any quality control / assurance be required in follow up to the clinical testing performed.

_____
Mother / Legal Guardian's Name

_____
Date (DD/MMM/YY)

_____
Mother / Legal Guardian's Signature

_____
Father / Legal Guardian's Name

_____
Date (DD/MMM/YY)

_____
Father / Legal Guardian's Name

By signing below, I attest that I am the only parent / legal guardian of the individual from whom this sample was obtained.

_____
Parent / Legal Guardian's Signature

Proof of identify MUST be supplied (photocopies only):

1. Birth certificate, passport photo page, or driver's license.

If requestor is parent/legal guardian

1. Birth certificate or passport photo page of child; AND
2. Parent(s) birth certificate, passport photo page or drivers license; AND
3. If legal guardian, provide proof of guardianship.

Please send form, with photocopies of proof of identity to:
Division of Genome Diagnostics
BC Children's Hospital and BC Women's Hospital
2J40 -4500 Oak Street, Vancouver, BC V6H 3N1

Print Form **Save Form** **Clear Form**