

CONSENTIMIENTO BREVE PARA LAS PERSONAS QUE NO LEEN INGLÉS  
BASES GENÉTICAS DE LAS ARRITMIAS CARDIACAS  
INVESTIGACION LLEVADA A CABO EN MASONIC MEDICAL RESEARCH LABORATORY

Se le pide participar en un estudio de investigación.

Antes de dar su autorización, el investigador le deberá informar sobre:

- I. El propósito, procedimiento y duración del estudio
- II. las partes del estudio, si es que hay, que son experimentales
- III. la posibilidad de riesgos, incomodidades, y los beneficios del estudio
- IV. alternativas de participar en el estudio
- V. la manera en que su información personal se mantendrá confidencial.
- VI. la manera en que usted pueda recibir cuidado médico si usted es lastimado en el estudio.
- VII. posibles riesgos del estudio
- VIII. posibles costes añadidos.
- IX. circunstancias en las que el investigador podría suspender su participación
- X. lo que pasaría si se decide retirar del estudio
- XI. las maneras en que usted sería notificado sobre nueva información del estudio, especialmente si esa información pudiera afectar su decisión de tomar parte en el estudio
- XII. Numero de personas que participaran en el estudio

Si usted acepta participar, le será dada una copia firmada de este documento y un resumen del proyecto.

Usted puede contactar al Dr. RAMON BRUGADA, Director del programa de Genética molecular, Masonic Medical Research Laboratory, 2150 Bleecker St, Utica, NY 13501, USA teléfono (315) 735-2217 en cualquier momento que tenga preguntas sobre la investigación o si piensa que se puede herir a causa del estudio. Usted puede comunicarse con LUCILLE ROTUNDO, BSN, OCN, Faxton-St. Luke's Helathcare, secretaria del IRB con teléfono (315) 624-4390 si tiene alguna pregunta sobre sus derechos como participante en un estudio investigativo o lo que debe hacer si se lastima.

Sus preguntas deben ser contestadas a su satisfacción antes de que usted firme este formulario. Usted puede elegir no participar en el estudio o puedo retirarse del estudio en cualquier momento sin perder los privilegios a los cuales usted tiene derecho.

Su firma en este formulario significa que el estudio de investigación ha sido descrito oralmente en el lenguaje que usted entiende, incluyendo la información anterior, y que voluntariamente acuerda participar.

Firma del Participante:	_____	Fecha: __/__/__
Firma del Representante legal:	_____	Fecha: __/__/__
Firma del Testigo:	_____	Fecha: __/__/__
Firma del Intérprete:	_____	Fecha: __/__/__
Firma del Investigador:	_____	Fecha: __/__/__

CONSENTIMIENTO PARA NINOS: Su firma indica que su niño \_\_\_\_\_ ha dado, dentro de los límites impuestos por la edad, madurez y estado psicológico, su consentimiento verbal para participar en el estudio.

**Consent Form for Human Subject Research**  
**Conducted at the Masonic Medical Research Laboratory**  
**Molecular Genetics Laboratory**  
**Molecular Genetic Basis for Brugada Syndrome – MMRL-002**

**IRB Reapproval 3/6/03**

**Background**

Some diseases are inherited, or passed from parent to child in some families. The material that is transmitted from parents to children is called DNA. The DNA contains some segments, called genes, which, when damaged, can cause disease to the patient. It is now possible to locate these genes in the DNA and analyze them for abnormal function. Identification of these altered genes in the individuals can help understand how the abnormal gene causes the disease. Identification of these genes requires the study of multiple individuals in families affected with the disease. This research study is sponsored by Doris Duke Charitable Foundation, American Heart Association and National Institutes of Health.

**Purpose**

The purpose of this study is the identification of abnormal genes responsible for familial inherited cardiac diseases like Brugada syndrome, Long QT syndrome, atrial fibrillation or familial bundle branch block. The information obtained will help advance the understanding of the disease being studied. The study will be recruiting individuals for the next 5 years and enroll about 500 patients.

**Procedures**

You will be one of approximately 500 subjects to be asked to participate in this trial. Adult individuals will be asked to donate blood (1-2 teaspoons). Children under 14 will be required maximum 1 teaspoon. DNA obtained will be used to determine whether the markers follow the disease gene within their particular family. While the individual will have completed his or her role in this project after giving blood, the linkage (or mapping) studies may go on for years before significant results are obtained. On occasion, if DNA is used up, that person may be asked to donate a small sample of blood once again. The samples will be stored in the form of DNA or cell lines in Dr Brugada's laboratory at the Masonic Medical Research Laboratory. As part of the genetic analysis different candidate genes will be analyzed over time. The DNA will only be used to identify genetic risk factors for cardiac arrhythmias. If the patient decides to withdraw from the study, or if the study is completed, the DNA will be returned or discarded per patient indication. The samples will not be sold or transferred to a third party or made available for other use. Because there is worldwide recruitment, my primary physician will explain the consent and the procedure and answer any questions that I may have.

**Potential Risks and Discomforts**

The only physical risk present in this study involves drawing blood from a vein, usually from the arm. Rarely bleeding (usually a very small amount) or infection, just like any other small scratch may occur. If any other procedure that requires drawing blood is already being performed, no

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added risk will occur due to this study. There is a potential risk in genetic testing for uncovering and conveying unwanted information regarding parentage or specific risk for disease.

### **Potential Benefits**

You have been told that the benefits of participating in this study may be: that the information obtained during this study might result in improved diagnosis in myself, some of my family members, or the general population at some time in the future. In this case, I will be offered the opportunity to be informed of the results, but may decline if I wish. However, I (or my family) may receive no benefit from participating in the study. The results of the testing will be made available to me or to my physician of my designation per my request. The primary physician will be in charge of providing genetic counseling or referring the patient to a genetic counselor if so I desire. However, you may receive no benefit from participating in this study.

### **Alternatives**

The only alternative to this study is non-participation.

### **Subject Costs and Payments**

There are no costs to you subject to your participation in this research study.

### **Subject's Rights**

There may be unknown risks/discomforts involved. You will receive any new information discovered during the course of this study, concerning significant treatment findings that may affect your willingness to continue participating in this research study.

Every effort will be made to maintain the confidentiality of your study records. The data from the study may be published; however, you will not be identified by name. The confidentiality of the data will be maintained within legal limits. In the event of injury resulting from this research, Masonic Medical Research Laboratory is not able to offer financial compensation nor to absorb the costs of medical treatment. However, necessary facilities, emergency treatment and professional services will be available to you, just as they are to the general community. Your signature below acknowledges your voluntary participation in this research project. Such participation does not release the investigator(s), institution(s), sponsor(s) or granting agency(ies) from their professional and ethical responsibility to you.

You may refuse to participate or may discontinue your participation AT ANY TIME, without penalty, loss of benefits, or change in present or future care. The investigator has the right to withdraw you from the study at any time. Your withdrawal from the study may be for reasons related solely to you (e.g. not following study-related directions from the Investigator, a serious adverse event reaction) or because the entire study is terminated. The Sponsor has the right to terminate the study or the Investigators participation in the study at any time.

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The investigator, RAMON BRUGADA, and/or his designee has attempted to answer all of your questions. If you have further questions or concerns, please address them with the study representative now. In the event of a research-related injury or if any other problems arise, you may contact: LUCILLE ROTUNDO, BSN, OCN, Faxton-St. Luke's Healthcare, IRB Secretary at (315) 624-4390. If questions/concerns arise during the course of the study, you may speak with the principal investigator, RAMON BRUGADA at (315) 735-2217.

Signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you voluntarily agree to participate in this research study.

_____	_____	
Subject	Date	
_____	_____	_____
Legal Representative or Next of Kin	Date	Relationship to Subject
_____	_____	
Investigator or Designee Obtaining Consent	Date	
_____	_____	
Witness (if applicable)	Date	
_____	_____	
Translator (if applicable)	Date	

### CHILDREN CONSENT

Your signature on this consent form attests to the fact that your child \_\_\_\_\_ has, within limits imposed by age, maturity, and psychological state, given his/her assent (affirmative agreement) to participate in this research project.

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