Research Consent Form for Social and Behavioral Research
Dana-Farber/ Harvard Cancer Center
BIDMC/BWH/CH/DFCI/MGH/Partners Network Affiliates OPRS 11-05

Protocol Title:
Epidemiology of Syndromic GI Stromal Tumors

DF/HCC Principal Research Investigator / Institution:
JUDY E. GARBER, MD, MPH, DANA-FARBER CANCER INSTITUTE

DF/HCC Site-Responsible Research Investigator(s) / Institution(s):
JUDY E. GARBER, MD, MPH, DANA-FARBER CANCER INSTITUTE

(Consent #1)

A. INTRODUCTION

We are inviting you to take part in a research study. Research is a way of gaining new knowledge. A person who participates in a research study is called a "subject" or "participant". This research study is evaluating the genetic and other features that are associated with inherited forms of GIST (gastrointestinal stromal tumors). The study is called **Project FLAG (Families Learning About GIST).**

It is expected that a total of about 800 people will take part in this research study, enrolling through their oncologist's office at Dana-Farber, or another participating program, or through a GIST support website (GIST Support International or the Life Raft Group).

An institution that is supporting a research study either by giving money or supplying something that is important for the research is called the "sponsor." The sponsor of this protocol is the National Cancer Institute (NCI), a division of the National Institutes of Health (NIH), which is providing funding for this research study.

This research consent form explains why this research study is being done, what is involved in participating in the research study, the possible risks and benefits of the research study, alternatives to participation, and your rights as a research subject. The decision to participate or not is yours. If you decide to participate, please sign and date at the end of the form. We will give you a copy so that you can refer to it while you are involved in this research study.

If you decide to participate in this research study, certain questions will be asked of you or certain tests will be taken to see if you are eligible to be in the research study. These tests are called screening tests. The research study has certain requirements that must be met. If the screening tests show that you can be in the research study, you will be able to enroll in the study. If the screening tests

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show that you cannot be in the research study, you will not be able to participate in this research study. We encourage you to take some time to think this over and to discuss it with other people and to ask questions now and at any time in the future.

B. WHY IS THIS RESEARCH STUDY BEING DONE?

GISTs are very rare tumors. The majority of GISTs do not occur in families. However, some families have inherited a greater tendency to develop GISTs, sometimes in association with certain skin findings or a tendency to other cancers as well.

The purpose of FLAG is to explore the inherited forms of GIST, since little is currently known about them, and individuals with GIST may want to know if their children and relatives have to be concerned for themselves. In FLAG, we will try to identify as many features as possible that are part of inherited forms of GIST. We have some clues – some benign skin findings and sometimes other rare cancers have been reported.

We also want to identify factors that may contribute to an inherited tendency to develop GISTs. In particular, FLAG will explore the inherited changes in the genes that have already been associated with inherited forms of GIST. Families who have a DNA change in GIST genes appear to be more likely to develop GIST, often in more than one relative. We would like to analyze the GIST genes of participants at higher risk of having hereditary GIST, and therefore, a higher chance that one of their GIST genes will contain an abnormality. We are hopeful that the information that we collect in this study can be used to assess a person's risk of developing GIST, and to develop good cancer screening recommendations for people at high risk of developing GIST.

Finally, individuals who enroll in FLAG may consent to become part of a registry of GIST families who may participate in future studies that seek to provide answers beyond this research study.

C. WHAT OTHER OPTIONS ARE THERE?

Taking part in this research study is voluntary. Instead of being in this research study, you have the following options:

- Decide not to participate in this research study
- Participate in another research study

- Obtain genetic counseling and/or genetic testing through available clinical programs

Whether or not you decide to participate in this study, you may still be able to obtain genetic counseling and/or genetic testing through clinical programs at this center or at other centers. If you have clinical testing, you may still enroll in this study if you are willing to share your information. If you decide not to participate in this study, your care at the institutions participating in the project will not be affected.

D. WHAT IS INVOLVED IN THE RESEARCH STUDY?

SCREENING PROCESS

If you have been diagnosed with GIST, you may be eligible to participate in all or part of FLAG. The screening process will determine which parts of the study you are eligible for. The screening process includes:

- **Consent Form**
  Carefully read and sign this consent form, which explains the study in detail. There are several checkboxes at the end of this consent form, which will allow you to select which parts of FLAG you would like to participate in. Please be sure to respond 'yes' or 'no' to all of the items.

- **FLAG Questionnaire**
  Fill out the FLAG Questionnaire, which should take you about 30 minutes to complete. The questionnaire asks for information on your personal and family cancer and health history. You may choose to skip any questions that you prefer not to answer. The information you provide will help us to determine which parts of this study you are eligible for. If you choose not to complete the questionnaire, you will not be able to enroll in FLAG.

- **Provide Blood or Saliva Specimen**
  You will be asked to provide either a blood or saliva sample either when you enroll (at your physician's office) or after you have spoken with the genetic counselor. If blood, 3-5 tablespoons (1-2 tubes) will be drawn from your arm by a trained phlebotomist. Alternatively, you may opt to provide a sample of your saliva instead of blood by spitting into a special container provided by the study. You may also choose not to provide either type of sample and not to enroll in this portion of the study. This sample will be held in the DFCI Sarcoma Specimen Bank until your screening for this study is completed, and

it is determined whether your sample will be submitted for genetic analysis of the GIST genes. If you are found to be eligible for genetic analysis, you will have the option at a later time to decide whether you wish to submit this blood or saliva sample for the genetic analysis (**Consent #2**). You will also have the option to store this sample in the DFCI Sarcoma Specimen Bank for later use by other investigators, whether or not it is used now for genetic analysis.

- **Medical Records Documentation**
  We request that you give us permission to obtain and review your medical records and pathology specimens pertaining to your diagnosis of GIST, other cancers, or other non-cancerous conditions that may be linked with inherited forms of GIST. Permission to view your GIST and other cancer history is required in order that we can be accurate about these diagnoses. You will need to complete page 18 of this consent to authorize us to collect your medical records regarding GIST and other potentially related conditions, such as skin examinations and biopsies and other cancers.

- **Genetic Education and Analysis**
  You will be contacted by a genetic counselor by telephone within about 2-3 weeks after you return the FLAG Questionnaire. She will review with you your personal and family history of cancer, skin findings and related medical issues. The information you provide will help to determine the chance that inherited factors contributed to your GIST. The genetic counselor will notify you whether your risk of hereditary GIST is estimated to be higher or lower, based on the information you provided on the FLAG Questionnaire. She will remind you about the issues in research genetic analysis, and will ask whether you wish to have your specimen analyzed for the GIST genes. Whether or not you agree to the genetic analysis, we will ask for your permission to use the information you provided on the FLAG Questionnaire for this research.

In order to compare genetic analysis results from individuals with lower and higher risk of having inherited GIST, we will also analyze the GIST genes from some, but not all, individuals with a lower chance of carrying an altered GIST gene. If you are found to have a lower risk of hereditary GIST, we will ask for your permission to do the genetic analysis, but since we cannot analyze every sample, we will let you know whether you have been selected to have your blood or saliva analyzed for the GIST genes. With your permission, your specimen will be stored with a unique study ID in the DFCI Sarcoma Specimen Bank for possible future investigational use.

If you decide to permit genetic analysis of your sample for the GIST genes, the genetic counselor will ask that you complete and return Project FLAG **Consent #2**. **Consent #2** describes in greater detail your options for handling the results of the research genetic analysis, which include: 1) deciding not to learn the research results, OR 2) deciding to learn the research results and give a new sample for final clinical results

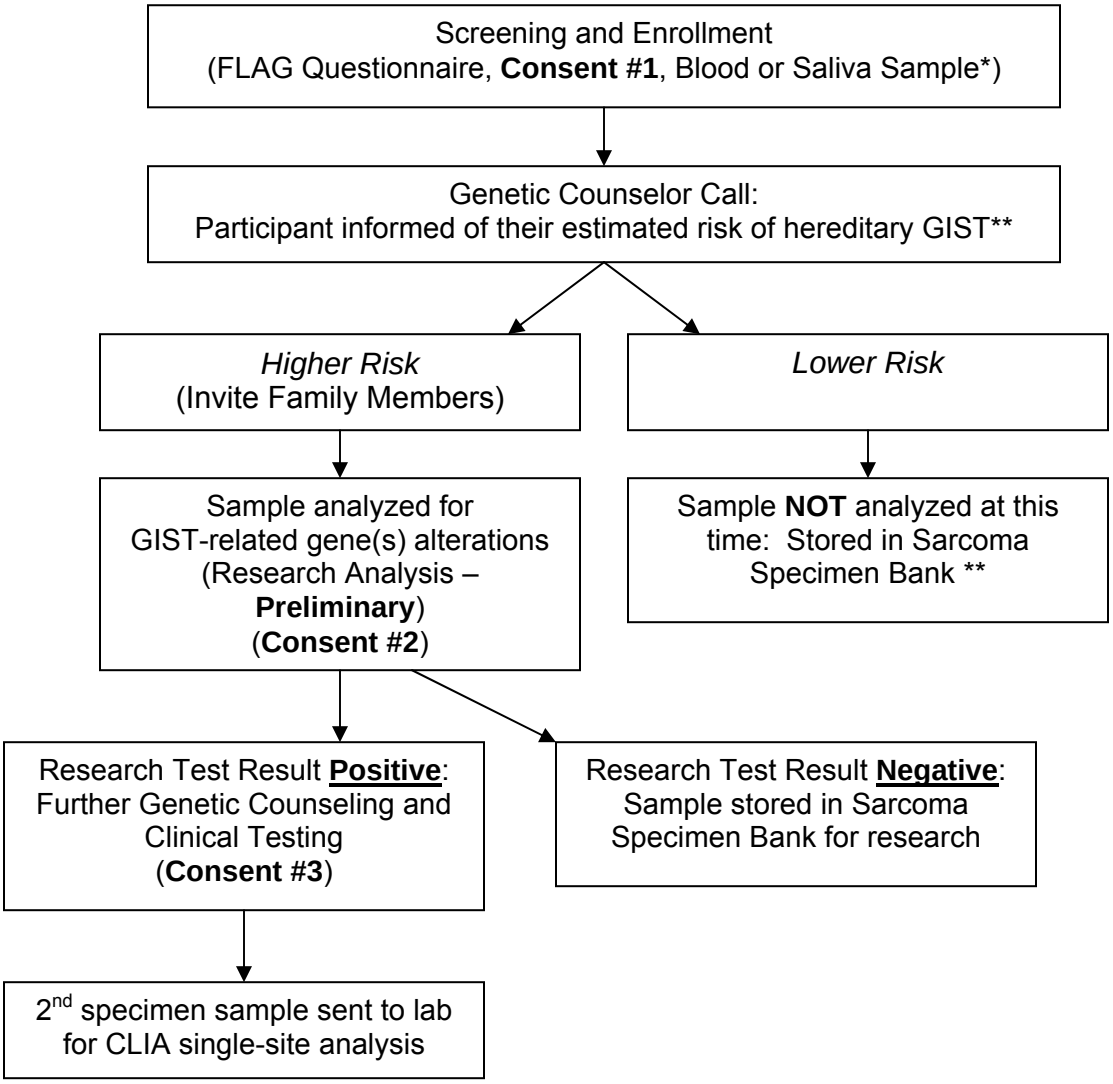
If you do not sign **Consent #2**, we will not analyze your blood or saliva specimen if you provided it. If you sign **Consent #2**, once we receive it from you, some of your blood or saliva sample will be sent to the laboratory for analysis of GIST genes. **Consent #2** details further information on genetic analysis, genetic counseling and molecular analysis.

The results of your research genetic analysis must be considered to be preliminary. You will be offered the opportunity to learn the results, or you may decide you do not want to know. If you learn your results, and a mutation in one of the GIST genes is found in your sample, we will ask you to provide a new sample so that the result can be confirmed in a clinical laboratory. If the clinical test is also positive, we will offer you the chance to involve relatives in Project FLAG, so that they, too, can consider genetic testing of their GIST genes. Details that might influence your decision are provided in **Consent #3**.

If no alterations are identified in the course of the research analyses, your specimen will be stored in the DFCI Sarcoma Specimen Bank, with your permission (below) to be used as part of efforts to identify other genes that may be associated with GIST. Some of these research efforts may involve researchers outside of Dana-Farber. When materials are shared between research laboratories, no information identifying any subject will be shared with any outside investigator.

The project is summarized in the following Project FLAG Patient Flow Chart:

Project FLAG Patient Flow Chart



***Specimen may be submitted later in the study.**
****Participant may stop at any point in the process.**

E. HOW LONG WILL I BE IN THIS RESEARCH STUDY?

You will be in this research study for about one year. If you permit your sample to be stored in the DFCI Sarcoma Specimen Bank for future investigational studies, then you will be enrolled in research for as long as your specimen is stored in the specimen bank.

The research team may decide to take you off the research study for many reasons including if:

- It is considered to be in your best interest
- The study procedures are found to be unsafe or ineffective
- There is any problem with following study procedures
- There are any problems with research funding
- Or for any other reason

If you are removed from the research study, the research Investigator will explain to you why you were removed.

F. WHAT ARE THE RISKS OR DISCOMFORTS OF THE RESEARCH STUDY?

There are risks to taking part in any research study.

1. Blood Draw: The risks of blood drawing are small and include superficial bruising or bleeding at the needle site.

2. People who participate in genetic education and counseling may experience psychological distress upon learning that they and family members could carry a genetic change associated with an increase in their risk of developing GIST or other cancers.

3. Before you would have your GIST genes analyzed, you would learn from the genetic counselors about other potential issues raised by genetic analysis, including concerns about privacy, insurance discrimination and affects on family relationships. Additional detailed information is found in the other study consents you would review before participating in that component of the FLAG project.

4. If you are eligible to have your sample participate in genetic analysis to look for alterations in your GIST genes, you will be offered genetic education, and the genetic counselor will call to review a second consent

and provide information about the process. You may also be offered genetic counseling and clinical genetic testing. There may be additional risks associated specifically with genetic testing; these are detailed further in **Consent #3**. Your participation in this study does NOT require that you undergo GIST genes analysis. The choice about whether to pursue testing is ultimately yours alone.

There may also be side effects other than those listed above that we cannot predict. During the research study, you will be provided with any new information that may affect your health or willingness to participate. You may be asked to sign a new consent form that shows that you have been informed of new information relating to this research study.

G. WHAT ARE THE BENEFITS OF THE RESEARCH STUDY?

Taking part in this research study may or may not benefit you directly. We hope the information learned from this research study will provide more information about the features associated with inherited forms of GIST for individuals and families with this condition and allow clinicians to develop appropriate screening recommendations for at-risk individuals.

H. CAN I STOP BEING IN THE RESEARCH STUDY AND WHAT ARE MY RIGHTS?

You have the right to choose not to sign this form. If you decide not to sign this form, you cannot participate in this research study.

You can stop being in the research study at any time. Leaving the research study will not affect your medical care in any way.

If you choose not to participate, if you are not eligible to participate in additional aspects of the study, or if you withdraw from this research study at any time, this will not affect your present or future care and will not cause any penalty or loss of benefits to which you are otherwise entitled. If you decide to withdraw from the study, we ask that you notify the investigators in writing.

I. WHAT ARE THE COSTS?

Taking part in this research study will not lead to added costs to you or your insurance company. The Dana-Farber Cancer Institute will receive no reimbursement for your participation in this study.

If you are eligible to participate in additional aspects of the research study and you elect to participate in these portions of the study, you will not be charged for the following:

- Genetic counseling
- Genetic analysis and confirmatory clinical testing

Additional screening that may be recommended if you are found to carry an altered GIST gene will not routinely be covered by the study.

You or your insurance company will be charged for other portions of your care during this research study that are considered standard care. You may be responsible for co-payments and deductibles that are standard for your insurance coverage. For example, if you have been diagnosed with a GIST, you would continue to have treatment as has been recommended by your oncologist. These services are not part of this research and you may have to pay for these yourself.

If you have questions about your insurance coverage, or the items you might be required to pay for, please call financial services for information. The contact information for financial services:

- Dana-Farber Cancer Institute: (617) 632-3455
- Brigham and Women's Hospital: (617) 732-5524 or (617) 732-7485

The National Cancer Institute provides an online resource to help people participating in cancer clinical trials understand which services their insurance company is required by law to pay. This can be found at the website below.

http://www.cancer.gov/clinicaltrials/learning/insurance-coverage

On rare occasions, laboratory research on human specimens results in discoveries that are the basis for new research products or diagnostic and therapeutic methods. It is not the policy of Dana-Farber Cancer Institute to compensate you for any future financial claim to your tissues for research and development for commercial and non-commercial purposes.

You should not expect anyone to pay you for pain, worry, lost income, or non-medical care costs that may occur from taking part in this research study.

J. WHAT HAPPENS IF I AM INJURED OR SICK BECAUSE I TOOK PART IN THIS RESEARCH STUDY?

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them.

Providing your care does not mean that DF/HCC or the research Investigators are at fault, or that there was wrongdoing. There are no plans for DF/HCC to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of this research study as soon as possible. The research Investigator's name and phone number are listed in this consent form.

K. WHAT ABOUT CONFIDENTIALITY?

We will take measures to protect the privacy and security of all your personal information, but we cannot guarantee complete confidentiality of study data.

Medical information created by this research study may become part of your hospital medical record. Information that does not become part of your medical record will be stored in your study file. If you are a Dana-Farber Cancer Institute patient, it may also become part of a DF/HCC research database called CORIS. The results of this research study may be published. You will not be identified in publications without your permission.

Efforts will be made to protect your medical records and other personal information to the extent allowed by law. However, we cannot guarantee absolute confidentiality. Medical records of research study participants are stored and kept according to legal requirements. You will not be identified in any reports or publications resulting from this study. Organizations that may request to inspect and/or copy your research and medical records for quality assurance and data analysis include such groups as:

- The National Institutes of Health
- Federal research oversight agencies

Data Security

Information about your participation in this study will be stored in a secure computer. All files pertaining to this study will be kept in a locked office to which only study staff will have access. Access to the computer and to all other information stored on the computer is password protected. Test results and other sensitive personal information will never be stored in the same file as your name or other identifying information.

L. CERTIFICATE OF CONFIDENTIALITY

This research study is being conducted by Dana-Farber Cancer Institute. To help protect your privacy, Dana-Farber Cancer Institute has obtained a Confidentiality Certificate from the Department of Health and Human Services (DHHS).

With this Certificate, Dana-Farber Cancer Institute cannot be forced (for example, by court subpoena) to disclose information that may identify you in federal, state, or local civil, criminal, administrative, legislative or other proceedings. Disclosure will be necessary, however, upon request of the Department of Health and Human Services for audit or program evaluation purposes.

You should understand that a Confidentiality Certificate does not prevent you or a member of your family or even the research Investigator from voluntarily releasing information about yourself or your involvement in this research. Note however, that if an insurer or employer, learns about your participation, and obtains your consent to receive research information, then Dana-Farber Cancer Institute may not use the Certificate of Confidentiality to withhold this information. This means that you and your family must also actively protect your own privacy.

M. WHOM DO I CONTACT IF I HAVE QUESTIONS ABOUT THE RESEARCH STUDY?

If you have questions about the study, please contact the study staff as listed below:

Dana-Farber Cancer Institute

- Judy E. Garber, MD, MPH, Principal Investigator: 617-632-2282
- Irene Rainville, MS, PhD, Genetic Counselor: 617-582-8537
- Study Manager: 617-632-5247
- Lisa DiGianni, PhD, Project Manager: 617-632-5429

For questions about your rights as a research participant, please contact a representative of the Office for the Protection of Research Subjects at DFCI (617) 632-3029. This can include questions about your participation in the study, concerns about the study, a research related injury, or if you feel/felt under pressure to enroll in this research study or to continue to participate in this research study.

N. PRIVACY OF PROTECTED HEALTH INFORMATION

Federal law requires Dana-Farber/Harvard Cancer Center (DF/HCC) and its affiliated research Investigators, health care providers, and physician network to protect the privacy of information that identifies you and relates to your past, present, and future physical and mental health conditions ("protected health information"). If you enroll in this research study, your "protected health information" will be used and shared with others as explained below.

1. **What protected health information about me will be used or shared with others during this research?**

   - Existing medical records
   - New health information created from study-related tests, procedures, visits, and/or questionnaires

2. **Why will protected information about me be used or shared with others?**

   The main reasons include the following:
   - To conduct and oversee the research described earlier in this form;
   - To ensure the research meets legal, institutional, and accreditation requirements;
   - To conduct public health activities (including reporting of adverse events or situations where you or others may be at risk of harm); and
   - Other reasons may include for intervention, payment, or health care operations. For example, some medical information produced by this research study may become part of your hospital medical record because the information may be necessary for your medical care.

3. Who will use or share protected health information about me?

- DF/HCC and its affiliated research Investigators and entities participating in the research will use and share your protected health information. In addition, other DF/HCC offices that deal with research oversight, billing or quality assurance will be able to use and share your protected health information.

4. With whom outside of DF/HCC may my protected health information be shared?

While all reasonable efforts will be made to protect the confidentiality of your protected health information, it may also be shared with the following entities:

- Outside individuals or entities that have a need to access this information to perform functions on behalf of DF/HCC and its affiliates (for example, data storage companies, insurers, or legal advisors).
- The sponsor(s) of the study, and its subcontractors
- Other research Investigators and medical centers participating in this research, if applicable
- Federal and state agencies (for example, the Department of Health and Human Services, the Food and Drug Administration, the National Institutes of Health, and/or the Office for Human Research Protections), or other domestic or foreign government bodies if required by law and/or necessary for oversight purposes.
- Hospital accrediting agencies
- A data safety monitoring board organized to oversee this research, if applicable

Some who may receive your protected health information may not have to satisfy the privacy rules and requirements. They, in fact, may share your information with others without your permission.

5. For how long will protected health information about me be used or shared with others?

- There is no scheduled date at which your protected health information that is being used or shared for this research will be destroyed, because research is an ongoing process.

6. Statement of privacy rights:

- You have the right to withdraw your permission for the research Investigators and participating DF/HCC entities to use or share your protected health information. We will not be able to withdraw all the information that already has been used or shared with others to carry out related activities such as oversight, or that is needed to ensure quality of the study. To withdraw your permission, you must do so in writing by contacting the researcher listed above in the section: "Whom do I contact if I have questions about the research study?"
- You have the right to request access to your protected health information that is used or shared during this research and that is related to your intervention or payment for your intervention, but you may access this information only after the study is completed. To request this information, please contact the researcher listed above in the section: "Whom do I contact if I have questions about the research study?"

DOCUMENTATION OF CONSENT

CONSENT TO PARTICIPATE

Consent of Subject: I_____ understand the purpose of this research and agree to participate and follow the procedures required. By signing this consent, I agree to the following points regarding this study:

(1) __**YES** __ **NO** (*please check one*) Allow researchers at Dana-Farber Cancer Institute to use my FLAG Questionnaire information for research purposes.

(2) __**YES** __ **NO** (*please check one*) Allow researchers at Dana-Farber Cancer Institute to collect information from my medical chart and my pathology specimens related to GIST for use in this research. (If yes, please complete the '*Consent for Release of Medical Records/Pathology Specimens'* on the last page of this consent.)

(3a) __**YES** __ **NO** (*please check one*) Provide a blood or saliva specimen from which DNA may be extracted and analyzed in a research laboratory for possible changes in genes associated with inherited forms of GIST and related cancers.

(3b) __**YES** __**NO** (*please check one*) Allow the collection of either a blood or saliva specimen for storage in the Dana-Farber Cancer Institute Sarcoma Bank for the purpose of cancer research.

(4) __**YES** __ **NO** (*please check one*) Allow researchers to re-contact me to discuss the possibility of enrolling other family members in this study.

(5) __**YES** __ **NO** (*please check one*) Allow researchers to re-contact me for other studies, which might be appropriate for my family or me.

(6) __**YES** __ **NO** (*please check one*) Allow researchers to re-contact me in the future to collect additional blood or other samples for the resource.

(7) __***YES*** __ ***NO*** (*please check one*) You may contact an additional person/next-of-kin in order to obtain my contact information, for study purposes only, in the event my provided contact information changes and you are unable to locate me.

Name of additional contact person/next-of-kin:_____

Relationship (parent, spouse, child, friend):_____

Address:_____

Phone Number:_____ Email: _____

My signature below indicates my willingness to participate in this research study and my understanding that I can withdraw at any time.

_____ _____
Signature of Subject Date

To be completed by person obtaining consent:

The consent discussion was initiated on _____ (date) at _____ (time.)

☐ A copy of this signed consent form was given to the subject or legally authorized representative, or, where the subject is a minor, the subject's parent or legal guardian.

For Adult Subjects

☐ The subject is an adult and provided consent to participate.

☐ The subject is an adult who lacks capacity to provide consent and his/her legally authorized representative:

- ☐ gave permission for the adult subject to participate
- ☐ did not give permission for the adult subject to participate

Signature of Individual obtaining consent: _____

Printed name of above: _____

Date: _____

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CONSENT FOR RELEASE OF MEDICAL RECORDS/PATHOLOGY SPECIMENS

Please fill out this form as completely as possibly and give as much information as you can about each cancer diagnosis or related medical condition.

Patient's Name_____Patient's Date of Birth_____

Name of First Diagnosis, Age, Dates of Treatment	
Name of Hospital City, State	
Doctor/Surgeon's name(s)	

Name of Second Diagnosis, Age, Dates of Treatment	
Name of Hospital City, State	
Doctor/Surgeon's name(s)	

For the purposes of medical research, I give Judy Garber MD, Suzanne George MD, George Demetri MD, their Co-Investigators or their appointed representatives permission to review my medical records, operative notes, pathology reports, discharge summaries, and pathology specimens related to GIST or associated conditions.

Signature _____ Date _____

Relationship to Patient (self, parent, guardian) _____

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