

TRUST LOGO (if applicable), or a placeholder, ‘local logo/letterhead’

Departmental Header if desired.

Add contact details of the

local research team and

either the Chief or Local Investigator

*Study Code: Site ID Code: Participant identification number:*

**CONSENT FORM**

**<Study Title>:** the title could be the same as in the protocol or a simplified version understandable to a lay person

**Researcher to seek and record informed oral consent, after participant has had sufficient time to think about whether they want to take part.**

Please check the boxes to record that the question has been asked by the researcher and that the participant has responded in the affirmative:

|  |  |  |
| --- | --- | --- |
| 1. (*Required*) Do you confirm that you have read the information sheet dated.................... (version............) for this study? Have you had the opportunity to consider the information, ask questions and have these answered satisfactorily? |  | |
| 1. (*Required*) Do you understand that your participation is voluntary and that you are free to withdraw at any time without giving any reason, without your medical care or legal rights being affected? |  | |
| 1. (*Required*) Do you understand that relevant sections of your medical notes and data collected during the study may be looked at by individuals from University of Oxford, from regulatory authorities <and from the NHS Trust(s)>, where it is relevant to your taking part in this research? Do you give permission for these individuals to have access to your records? |  | |
| 1. (*If relevant*) Do you agree to donate<state samples>. and consider these samples a gift to the University of Oxford? Do you understand you will not gain any direct personal or financial benefit from them? |  | |
| 1. (*If relevant*)) Do you agree to the <interview/focus group> being <audio/video> recorded? |  | |
| 1. (*If relevant*) Do you agree to your General Practitioner being informed of your participation in the study? |  | |
| 1. (*If relevant*) Do you understand that the information held and maintained by NHS England / NHS Central Register may be used to help contact you or provide information about your health status? |  | |
| 1. (Genetic research, *if relevant*) Do you understand and agree that your samples will be used in research aimed at understanding the genetic influences on disease and that the results of these investigations are unlikely to have any implications for you personally? |  | |
| 1. (*Scans, if relevant*): Do you understand that scans are not useful for medical diagnosis, and are not routinely looked at by a doctor? If a concern is raised about a possible abnormality on your scan, you will only be informed if a doctor thinks it is medically important such that the finding has clear implications for your current or future health. |  | |
| 1. (*Required*) Do you agree to take part in this study? |  | |
| Additional: |  | |
| 1. (*If relevant*): Do you agree to be contacted about ethically approved research studies for which you may be suitable? Do you understand that agreeing to be contacted does not oblige you to participate in any further studies? | Yes | No |
|  |  |
| 1. (*If relevant*): Do you agree for your samples to be used, in a form that does not identify you, in future research here or abroad, which has ethics approval.. Do you understand this research may involve commercial organisations? | Yes | No |
|  |  |

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name of Participant*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name of Researcher taking consent Date Signature*

When completed: 1 for participant (e.g. emailed securely to participant); 1 for researcher site file (original); 1 to be kept in medical notes (if participant is a patient).