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| Participant ID: 13849 / | Initials: |
| Date of Birth: | NHS/Hospital Number: |
| ISRCTN: 13927531 | Principal Investigator: Professor Andy Clegg |

PARTICIPANT CONSENT FORM

| | | Please tick each box |
|----|--|----------------------|
| 1 | I confirm that I have read and understand the information sheets for the above study and have had the opportunity to ask questions. | |
| 2 | I understand that my participation in this study is voluntary and that I am free to withdraw at any time without my medical care or legal rights being affected. | |
| 3 | I understand that even if I withdraw from the above study, the data collected from me will be used in analysing the results of the study unless I request otherwise. | |
| 4 | I agree to undertake trial specific assessments to confirm my eligibility to take part. | |
| 5 | I agree for my medical records (primary care and hospital records), including my electronic health records to be reviewed by a study researcher. | |
| 6 | I agree for my personal details (which will include my name, date of birth, postcode, and NHS number) to be shared with Electronic Health Record systems (including but not limited to NHS Digital, SystemOne, EMIS) so that information about my healthcare use can be obtained by the study team (Data Linkage). | |
| 7 | I agree for my personal details (including name, date of birth, postcode, and NHS number) to be securely stored in accordance with the study sponsor guidance (10 years). | |
| 8 | I agree for access and use of data about me, as described above, to continue in the event of my death. | |
| 9 | I understand that my healthcare records may be looked at by authorised individuals from the study team, regulatory bodies or Sponsor in order to check that the study is being carried out correctly. | |
| 10 | I agree to allow any information or results arising from this study to be used for healthcare and/or further medical research upon the | |

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| | understanding that my identity will remain anonymous wherever possible. | |
| 11 | I agree to a copy of this Consent Form being sent to the CTRU | |
| 12 | I agree that my GP, or any other doctor treating me, will be notified of my participation in this study. | |
| 13 | I agree to take part in the study. | |

Patient:

Signature.....

Name (block capitals).....

Date.....

Investigator:

I have explained the study to the above named patient and he/she has indicated his/her willingness to participate.

Signature.....

Name (block capitals).....

Date.....

(1 copy for patient; 1 for the CTRU; 1 held in patient notes, original stored in Investigator Site File)