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| [Sponsor logo  (if different)]  [Collaborating  group logos]  [Funder logo]  [Research  network logo  (if applicable)] | Consent Form to the ACRONYM Protocol | | |
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|  | Version: | 1.0 | |
|  | Date: | 01 Jan 2011 | |
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|  | MRC CTU ID: | |  |
|  | ISRCTN #: | | ISRCTN# |
|  | NCT #: | |  |
|  | EudraCT #: | |  |
|  | CTA #: | |  |
|  | MREC #: | |  |
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Patient-related Information

Template Consent Form

**Research Study Title (Acronym & full title)**

**[Adult] Patient Informed Consent Form**

(To be presented on local headed paper)

[*Insert Info*: Date & Version]

Centre Name & Number: ………………………………....

Patient ID Number: …………………………………….…….

Name of Researcher: ………………………………………..

Initial boxes to agree

1. I confirm that I have read and understood the information sheet for the [*Insert Info*]research study [*Insert Info*: Date & Version] and have been given a copy to keep. I have had the opportunity to ask questions about the project and the use of my personal data and discuss it with my doctor and I have received satisfactory answers to all of my questions.

2. I understand that sections of any of my medical notes may be looked at by responsible individuals from the Medical Research Council (MRC) Clinical Trials Unit (CTU), [*Insert Info*] (e.g. drug companies involved in the study) or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records, but understand that my confidentiality will be maintained.

3. In order to follow up on my health status after my participation in the trial, I give permission for my personal details to be used to obtain information about my health status, for example, from records held by the NHS and maintained by the NHS Information Centre and the NHS Central Register or any applicable NHS information system.

4. I understand that my GP will be informed of my participation in the research study.

5. I understand that I may not benefit directly by participating in this study but that the research may help people with this condition in the future.

6. I understand that my participation in all aspects of this trial is voluntary and that I am free to withdraw from the trial at any time, without giving any reason and without my medical care or legal rights being affected.

7. I agree to take part in the above study.

8. I give permission for a copy of this consent form to be sent to the MRC CTU (where it will be kept in a secure location before being destroyed), to show that my consent was given. (If you do not wish to give this permission, do not put your initials in the box – you can still take part in the trial).

9. I agree to participate in the Quality of Life/Health Economics/Sub- study and to complete these questionnaires. (If you do not wish to give this permission, do not put your initials in the box – you can still take part in the trial).

10. I give permission for my stored samples to be made available for future research where the samples would be stored appropriately and the research approved separately. I understand that some of these projects may be carried out by researchers other than the MRC. I understand that the results of these research projects are unlikely to have any implications for me personally. (If you do not wish to give this permission, do not put your initials in the box – you can still take part in the trial).

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| Name of Patient (BLOCK CAPITALS) |  | Date (dd/mm/yyyy) |  | | Signature |
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| Name of Researcher (BLOCK CAPITALS) |  | Date (dd/mm/yyyy) |  | | Signature |
|  |  |  |  | |  |
|  |  |  |  | |  |
| Name of Person asking for consent (if different from researcher) (BLOCK CAPITALS) |  | Date (dd/mm/yyyy) |  | | Signature | |

Please sign 1 copy and take 3 photocopies: 1 copy to be kept by the patient, 1 copy to be kept with hospital notes, 1 to be kept in the local investigator’s file and 1 to be sent to MRC CTU (if box [*Insert Info*]is initialled) with patient name omitted.