[redacted]

[Print on hospital headed notepaper]

Centre Number: ***[insert centre number]***
Study Number:
Participant ID Number: ***[insert patient ID number]***

CONSENT FORM

Title of Project:
Low-dose Intravenous Immunoglobulin Treatment for Complex Regional Pain Syndrome (LIPS)

Name of Researcher: *[insert site principal investigator name]*

Please do not tick but initial the relevant box to confirm your consent.

I confirm that I have read and understand the information sheet, Version 3.0 dated 02.09.2013 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

1. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

2. I understand that relevant sections of any of my medical notes and data collected during the study may be looked at by responsible individuals from the study co-ordinating centre, the CLRN research network, representatives of the sponsor or the NHS trust, the ethics committee and 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. ☐

3. I agree to my GP being informed of my participation in the study. ☐

4. I understand that information held by the NHS may be used to keep in touch with me and follow up my health status. ☐

5. I agree to give a gift of research blood samples for the study (optional). If I do not wish to give a gift of blood samples for research I understand that I can still take part in the LIPS treatment trial. I understand that the research bloods will be used to research chronic pain conditions. ☐

6. I agree to receive daily text messages to my mobile phone reminding me both to enter my daily pain intensity into my pain diary, and to text my daily pain intensity to a free phone number (optional). ☐

Name of Participant	Date	Signature
Name of Witness (if patient cannot give written consent)	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature