

VenUS IV: Patient Consent Form

Patient's initials:	<input type="text"/>	Patient's Date of Birth	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<i>day</i>		<i>month</i>		<i>year</i>		
Name of researcher:	<input type="text"/>								

Please read the following ten statements and, if you agree and would like to participate in this study, add your initials inside each box. Ask the nurse with you if you have any questions or would like the statements to be read to you. Finally, if you agree with all the statements, please sign your name at the bottom of the page. By doing this you will have consented to take part in the VenUS IV study.

- | | Please
initial
each box |
|---|-------------------------------|
| 1. I agree to take part in the VenUS IV study | <input type="text"/> |
| 2. I confirm that I have read and understood the information sheet dated 18/06/2009 for the above study and have had the opportunity to ask questions | <input type="text"/> |
| 3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected | <input type="text"/> |
| 4. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports of this study | <input type="text"/> |
| 5. I understand the compensation provisions for this study | <input type="text"/> |
| 6. I understand that data collected as part of this trial will be stored for 5 years | <input type="text"/> |

One copy to participant; one copy for participant's notes; original to York Trials Unit.

7. I understand that anonymised data may be used in the future for further analysis strictly in connection with this study

8. I agree that responsible individuals nominated by the funders of this study or the University of York may access my medical and nursing records in relation to my taking part in this study

9. I agree that any identifiable study data collected can be retained in the event of loss of capacity to consent to further participation

10. I agree to my GP being informed of my participation in this study

Patient name (please print) _____

Signature _____

Date _____

Name of researcher taking consent (please print)

Signature

Date

/

/

Day

Month

Year