**PARTICIPANT CONSENT FORM**  (amend as needed)

**Study Title**: ……………………………….

Researcher’s name and contact details…………………………

Participant ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please initial box

 (or tick box, if online)

|  |  |
| --- | --- |
| 1. I confirm that I have read and understood the Participant Information Sheet (Version XX dated DD MM YYYY) for the above study
 |  |
| 1. I have been given the opportunity to consider the information provided, ask questions and have had these questions answered to my satisfaction
 |  |
| 1. I understand that my participation is voluntary and that I can ask to withdraw at any time without giving a reason and without my medical care or legal rights [ensure same as stated in PIS] being affected
 |  |
| 1. (If appropriate) I understand that my anonymised data will be stored for a minimum of X years and may be used in future ethically approved research
 |  |
| 1. (If appropriate) I understand that relevant sections of my (medical notes) and data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data (and/or medical records)
 |  |
| 1. (If appropriate)I am aware that participating in this study at the current time may carry risks in relation to potential exposure to coronavirus, and I understand the steps that have been taken in relation to minimise the risks of exposure and transmission
 |  |
| 1. (If appropriate) I agree to my General Practitioner being informed of my participation in the study
 |  |
| 1. (If appropriate) I agree to my interview being audio/video (delete as appropriate) recorded
 |  |
| 1. (If appropriate) I agree to my audio/video (delete as appropriate) recorded interview being transcribed by a third party contractor
 |  |
| 1. I agree to take part in the above study
 |  |

 (the below signature spaces can be replaced by the above tick box, if Consent is online)

Name of person giving consent Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person taking consent Date Signature

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(remove the following instructions if Consent is online)

1x original – into Site File; 1x copy – to Participant; 1x copy – into medical records (if appropriate)