



Participant ID: _____

University Hospital Southampton



NHS Foundation Trust

Consent Form

A prospective study to evaluate the real-world diagnostic accuracy and potential clinical impact of the Veros COVID-19 test in adults presenting to the Emergency Department with suspected COVID-19: ED-POC

Chief Investigator: Professor Tristan W Clark

Please put your INITIALS in each box and sign at the end of the form, indicating your consent to the following:

1. I confirm that I have read and understood the Participant Information Sheet dated...../...../..... (Version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation in research is voluntary and that I am free to withdraw at any time, without giving a reason or my care/legal rights being affected.
3. I agree to have an anterior nasal swab taken, in addition to the routine SARS-CoV-2 nose and throat swab. I understand this will be tested for SARS-CoV-2 on a new kind of COVID-19 test and that the results of this test will not be shared with me or my doctors and nurses.
4. I agree to have an additional nose and throat swab taken, and that this sample may be sent for viral culture.
5. I give permission for relevant sections of my medical notes, including electronic records and research data, to be accessed by the research team, responsible individuals from regulatory authorities, the University of Southampton and University Hospital Southampton NHS Foundation Trust, for the purposes of the study.
6. I understand that any samples collected from me may be kept for the purpose of further ethically approved research. *(Optional)*
7. I agree to take part in this study.

Participant Signature:

Participant Name (ideally print):

Date:/...../.....

Researcher Taking Consent Signature:

Date:/...../.....

Researcher Taking Consent Name:

When a participant has capacity to give consent but is physically unable to complete this form, a witness may complete this form on their behalf including participant initials, name, and date. Please put the witness' name, signature and date here:

Witness Signature:

Date:/...../.....

Witness Name:

When completed: original to be placed in the Investigator Site File, with copies for the participant, the medical notes, and the witness (where applicable).