

HIPPO TRIAL

IMMEDIATE PATIENT CONSENT FORM

IRAS ID: 1008285

REC reference: 24/LO/0914

Name of Principal Investigator: Zudin Puthucheary
Site Name: Royal London Hospital

Trial ID:

How was consent received (please tick one box) ☐ face to face

Please initial box

1. I confirm that I have read and understand the information sheet dated **xx/xx/xxxx**, version **xx** for the *HIPPO trial*.
I understand that I am being asked to say whether I wish to take part in this research study. I have had the opportunity to consider the information, ask questions and had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, or my medical care or legal rights being affected.
3. I understand that parts of my medical notes and data collected during the trial may be looked at by the research team, the sponsor (and its representatives), the regulatory authorities, or the NHS Trust where it is relevant to this research. I give permission for these individuals and bodies to have access to my records.
4. I agree to being contacted by telephone for follow-up around day 30, after being enrolled in the study.
5. I agree for the research team to contact my primary care practitioner (GP) to inform them of my involvement in this study.
6. I understand that data collected for this trial will be used for study analysis. I understand that I will not be identifiable in any publication or other study outputs resulting from this trial. I agree for my data to be securely stored and archived by Queen Mary University of London and Swansea University
7. I agree to taking part in the *HIPPO trial*.

Please initial YES or NO

YES

NO

8. I agree for my anonymised data to be shared with other researchers for further ethically approved research and resulting research publications.

9. I agree that anonymised samples of my blood will be used for purposes of closely related ethically approved research in future

Print name of participant:

Date:

Signature (if applicable):

Print name and role of person
receiving consent:

Date:

Signature:

Name:

Role:

Print name of PI/Medical Delegate:

Date:

Signature:

If a participant is unable to read or sign this consent form but has capacity to give consent, please complete the following section.

☐

Face to face consent with witness

The participant was unable to read or sign this consent because of the following reason:

I confirm that I was present as a witness to this consent process. I confirm that the participant named above was read the information in the consent document, if needed, and freely gave their consent to take part in the trial.

Name and role of witness

Date

Signature

Name:

Role:

When completed, give one copy to the patient; file the original in the Investigator Site File; and file one copy in the medical notes.