

Hospital-acquired Infection Prevention with Parenteral Omegaven- HIPPO

PERSONAL LEGAL REPRESENTATIVE 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 ☐ telephone.

Please initial box

1. I confirm that I have read and understand the information sheet dated **xx/xx/xxxx**, version **xx** (Personal Consultee) for the *HIPPO trial*.
I understand that I am being asked to say whether would 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 friend/relative's participation is voluntary and that I am free to withdraw them/ they are free to withdraw at any time, without giving a reason, or their medical care or legal rights being affected.
3. I understand that parts of my friend/relative's 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 their records.
4. I agree for my friend/relative to be 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 friend/relative's primary care practitioner (GP) to inform them of their involvement in this study.
6. I understand that data collected for this trial will be used for study analysis. I understand that my friend/relative will not be identifiable in any publication or other study outputs resulting from this trial. I agree for my friend/relative's data to be securely stored and archived by Queen Mary University of London and Swansea University
7. I agree to my friend/relative taking part in the *HIPPO trial*.

Please initial YES or NO:

YES NO

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

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9. I agree that anonymised samples of my friend/relative's blood will be used for purposes of closely related future ethically approved research.

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Print name of participant: _____

Print name of person giving consent
(**Personal Legal Representative**):

Date:

Signature:

Name: _____

Relationship to patient:

Print name of person receiving consent:

Date:

Signature:

Name: _____

Role: _____

Print name of PI/Medical Delegate:

Date:

Signature:

If the Personal Legal Representative is providing consent via telephone, please complete the following section.

I confirm that I witnessed the person receiving consent has initialled the correct boxes according to the Personal Legal Representative's will. I can confirm that the Personal Legal Representative has considered the above and freely gave their consent for the patient to take part in the trial.

Notes/actions arising from the telephone call

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Name and role of witness:

Date:

Signature:

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