###  PLEASE INSERT NAME & ADDRESS OF DEPARTMENT

St. Vincent’s University Hospital

Elm Park, Dublin 4,

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# PARTICIPANT INFORMATION AND CONSENT FORM

STUDY TITLE:

# NAME OF PRINCIPAL INVESTIGATOR:

You are being invited to participate in a research study. Thank you for taking time to read this.

# WHAT IS THE PURPOSE OF THIS STUDY?

The aim of the study is to

# WHY HAVE I BEEN CHOSEN?

# WHAT WILL HAPPEN IF I VOLUNTEER?

Your participation is entirely voluntary. If you initially decide to take part you can subsequently change your mind without difficulty. This will not affect your future treatment in any way. Furthermore your doctor may decide to withdraw you from this study if (Insert/delete as appropriate), he/she feels it is in your best interest.

If you agree to participate, you will be requested to ( Insert/delete as appropriate), eg: donate a blood, tissue, urine sample, complete a questionnaire or interview etc.

**Specify, sample volume** which should be quantified in terms of tsps/tablsps

(Insert/delete as appropriate) If additional time and/or visits are required this should be clearly stated and include **how long** and **how many** and **where they will take place.**

# ARE THERE ANY BENEFITS FROM MY PARTICIPATION?

Delete as appropriate You will/will not benefit directly from taking part in this study but the information we will obtain may provide further knowledge of this condition.

# ARE THERE ANY RISKS INVOLVED IN PARTICIPATING?

There are risks associated with this study.

Please enumerate and quantify **all** possible risks (eg: blood sample risks: bruising at site, swelling, dizziness, fainting, infection at site etc)

# WHAT HAPPENS IF I DO NOT AGREE TO PARTICIPATE?

If you decide not to participate in this study your treatment will not be affected in any way.

# CONFIDENTIALITY

Include/Delete as necessary:

Your identity will remain confidential. A study number will identify you. Your name will not be published or disclosed to anyone.

# COMPENSATION

Your doctors are adequately insured by virtue of their participation in the Clinical Indemnity Scheme.

# WHO IS ORGANISING AND FUNDING THIS RESEARCH?

Include/Delete as necessary:

This study is organised and funded by

Will I be paid for taking part in this study?

Will my expenses be covered for taking part in this study?

# HAS THIS STUDY BEEN REVIEWED BY AN ETHICS COMMITTEE?

The St. Vincent’s Healthcare Group, Ethics and Medical Research Committee have reviewed and approved this study.

# CONTACT DETAILS

Include: contact details for further information**.**

**Please note:**  Telephone number should be study specific.

**RESEARCH PARTICIPANT’S RIGHTS**

If you have any questions about your rights as a research participant, then you may contact the Hospital’s Quality & Patient Safety Department 01 2214013

# PLEASE TICK YOUR RESPONSE IN THE APPROPRIATE BOX

* I have read and understood the Participant Information YES NO
* I have had the opportunity to ask questions and discuss the study YES NO
* I have received satisfactory answers to all my questions YES NO
* I have received enough information about this study YES NO
* I understand that I am free to withdraw from the study at any time without

giving a reason and without this affecting my future medical care YES NO

* I agree to take part in the study YES NO

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Participant’s Name in print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Investigator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

 Investigator’s Name in print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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