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**Prevention of Respiratory Insufficiency after Surgical Management (PRISM) Trial**

PATIENT CONSENT FORM

Name of Principal Investigator: [Insert here]

Site Name: [Insert here] Trial ID: |\_\_|\_\_|\_\_| -|\_\_|\_\_|\_\_|\_\_|

**Please initial box**

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| --- | --- | --- | --- | --- |
| 1. | I confirm that I have read and understand the information sheet dated 3d July 2018 (version 1.2) for the PRISM trial. I have had the opportunity to consider the information, ask questions and have 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 sections of any of my medical notes and data collected during the trial, may be looked at by the research team, national or international co-ordinating centre, the sponsor (and its representatives), regulatory authorities, or the *NHS Trust/Health Board/international equivalent [delete as appropriate]* where it is relevant to this research. I give permission for these individuals to have access to my records. | | |  |
| 4. | I agree for the study team to contact my primary care practitioner (GP) in order to gather basic information about my health and to inform them of my involvement in this study. | | |  |
| 5. | I understand that information held and maintained by the Health and Social Care Information Centre and other central UK NHS bodies *or equivalent national records database [delete as appropriate]* may be used to help contact me and provide information about my health status. | | |  |
| 6. | I agree to take part in the PRISM trial. | | |  |
| Print Name of participant | | Date | Signature | |
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|  | |  |  | |
| Print Name of person taking consent  (designated responsible person) | | Date | Signature | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Print Name of researcher | | Date | Signature | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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