**ABBRUPT Trial**

**PATIENT CONSENT FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  |  |  | | --- | --- | --- | --- | | **Patient Trial Number:** ii I ii I ii I ii | | **Please initial each box to confirm consent**  **If the participant is unable to initial for themselves, the researcher will initial on their behalf ↓** | | | **1.** | I confirm that I have read (or had read to me) and understood the Patient Information Sheet version **iiLii . iiLii** dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for the above trial. I have had the opportunity to think about the information, ask questions and have had these answered to my satisfaction. | |  | | **2.** | I understand that my ongoing participation in this trial is **voluntary** and that I am free to withdraw at any time, without giving a reason and without my medical care or legal rights being affected. I understand that data collected up to my time of withdrawal may be used. | |  | | **3.** | I understand that sections of my medical notes or information related directly to my participation in this trial may be looked at by responsible individuals from the sponsor, regulatory authorities and research personnel where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. | |  | | **4.** | Information collected that identifies me by name, e.g. Consent Forms, will be transferred from where it is collected and stored at the University of Birmingham during the trial and then at a specialist, secure archiving facility, in compliance with current regulations, after the trial. I agree to the transfer and storage of this information. | |  | | **5.** | I understand that, if I lose capacity during the course of the trial, a legal representative will be asked to confirm ongoing consent on my behalf. | |  | | **6.** | I understand that a copy of this consent form and personal information about my progress will be sent in confidence to the central organisers at Birmingham Clinical Trials Unit (BCTU) for use in the ABBRUPT Trial. | |  | | **7.** | I agree to my GP being informed of my participation in the ABBRUPT Trial and for them to be contacted by members of the ABBRUPT Research Team for information about my health specific to the ABBRUPT Trial. | |  | |  |  | |  | | **8.**  **9.** | I agree to ongoing participation in the ABBRUPT Trial.  I understand that the information collected about me may be used to support other related research in the future. | |  | |  |  | |  | | **To continue participating in the ABBRUPT Trial you MUST consent to points 1-9 above and initial the corresponding boxes. Points 10 and 11 below are OPTIONAL; please only initial these boxes if you agree to the following:** | | | | | **10.** | I agree to have blood samples taken and stored for future biochemical tests to help understand new onset atrial fibrillation. These samples will be taken and stored on the understanding that the investigations are for medical research only and my results will be kept confidential. Any subsequent trial on this material is subject to Research Ethics Committee approval. I understand that these samples will be analysed in research laboratories outside this hospital, within the UK. | |  | | **11.** | If I am transferred to another hospital for further treatment, relating to my illness, I consent for the ABBRUPT Research Team to contact the hospital where I am receiving treatment, to request some information about my health specific to the ABBRUPT Trial. | |  | |  |

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| Name of participant |  | Date |  | Signature |

Witness only required if patient is physically unable to sign but has the capacity to give consent.

By signing below:

I witnessed accurate reading of the consent form to the potential patient, who could ask any questions

and got satisfactory replies. I confirm they gave their consent freely.

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| Name of witness |  | Date |  | Signature |

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| Name of person receiving consent |  | Date |  | Signature |

***Original to be filed in the Investigator’s Site File; 1 copy for patient; 1 copy to be kept with patient’s medical notes; 1 copy to be sent to BCTU***