

Insert initials
 in box
 YES or NO

Participant ID: _____

Taking Part

- | | | |
|---|------------------------------|-----------------------------|
| 1. I confirm that I have read and understand the information sheet for this project, and I have had the opportunity to ask questions. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. I understand that my samples and data will be kept for research unless informed otherwise. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. I understand that some of the projects may be carried out by researchers who work outside of this establishment and possibly outside the United Kingdom, including commercial companies. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. I understand that I will not benefit financially from any research that leads to the development of new treatments or medical tests in the future. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. I understand that DNA from the samples may be used for approved projects and as the samples are anonymised, the results of this analysis will not be available to me. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. I agree to make my contact details available to researchers that may have details of further studies that I may want to take part in | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Samples

- | | | |
|--|------------------------------|-----------------------------|
| 8. I agree for samples that will usually be discarded after routine tests, to be kept for research | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. I understand that during routine examination and sampling, I may be asked to donate an extra 2 or 3 samples for research. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. I agree to donate extra blood when undergoing a routine blood test. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. I agree to donate a mouth swab sample. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Data

- | | | |
|---|------------------------------|-----------------------------|
| 12. I understand that my clinical information may be looked at by responsible individuals from the biobank staff or NHS trust. I give permission for these individuals to have access to my records. I also understand that when tissue samples and data are collected and stored for use in research projects they will be linked-anonymised. Any external researchers will receive fully anonymised data. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|---|------------------------------|-----------------------------|

Name of Participant (BLOCK CAPITALS)

Date

Signature

Name of Person Taking Consent (BLOCK CAPITALS)

Date

Signature

Name of Witness (if required) (BLOCK CAPITALS)

Date

Signature

One copy to the patient, one copy in the medical notes and one copy for the biobank