CONSENT FORM

CONSENT FORM FOR PARTICIPATION IN ANGIODYSPLASIA STUDY

Protocol Number: .....

Participant Identification Number: .....

Title of Protocol: **Investigation into Bowel Angiodysplasia**

Name of Institution leading the Research : Department of Clinical Medicine, TCD

Research Director: Prof Deirdre McNamara

Phone Number and Contact Details: +353 1 896 2998
douglaar@tcd.ie

Please initial boxes

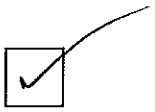
1. I have read the attached information sheet on the above project dated..... and have been given a copy to keep. The information has been fully explained to me and I have had an opportunity to ask questions about the project and understand why the research is being done and any foreseeable risks or consequences involved. I also understand that no guarantee can be given about the possible results. ☑

2. I agree to give a sample(s) of blood for research in the above project, total 20mls. I understand how the sample will be collected, that giving a sample for this research is voluntary and that I am free to withdraw my approval for use of the sample at any time without giving a reason. If I withdraw my consent I understand that my sample will be destroyed unless I otherwise authorise. I understand that I may ask for my samples to be destroyed and that this will be without my medical treatment or legal rights being affected. I agree that the samples I have given and the information gathered by me can be stored and looked after by the (name of institution). I understand that any genetic information obtained will / will not be made available to me. ☑

3. I give permission for my medical records to be looked at and information taken from them to be analysed in the strictest confidence by the relevant and responsible people from the Angiodysplasia Study Team under Prof McNamara or from organisations supervising the research. I have been told that all medical information / data pertaining to me will be protected by the principles of confidentiality and both national and E U data protection legislation. I have further been told of / shown assurances that this also applies to all medical information / data pertaining to me that are utilised in any non-E U state. ☑

4. I understand that the confidentiality of the sample(s) I donate and information derived therefrom will be protected. I have been told that all medical information / data pertaining to me and derived from the sample(s) will be protected by the principles of confidentiality and both national and E U data protection legislation. I have further been told of / shown assurances that this also applies to all medical information / data pertaining to me and derived from the sample(s) that are utilised in any non-E U state. ☑

5. I know how to contact the research team if I need to.



.....
Name of participant (BLOCK CAPITALS) **Date** 02-09-14 **Signature**

.....
Name of researcher **Date** 02-09-14 **Signature**

.....
Name of witness **Date** **Signature**