

*Patient name:*

**PARTICIPANT IDENTIFICATION #:** **[\_\_\_][\_\_\_][\_\_\_]- [\_\_\_][\_\_\_][\_\_\_][\_\_\_]**

[\*\*\*Hospital letter head\*\*\*]

Local lead investigator: [\*\*\*local\_lead\*\*\*]

**Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI)**

**INFORMED CONSENT FORM FOR PATIENT**

**01 February 2016. Version 1.0**

|  |  |  |
| --- | --- | --- |
|  |  | **Please initial box** |
| * I have read (or it has been read to me) the information sheet for this study. I understand the information and have had the opportunity to ask questions for clarification.
 |  |  |
|  |  |  |
| * I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason and without my medical care or rights being affected.
 |  |  |
|  |  |  |
| I understand that data will be collected from my medical records, including medications and laboratory results by study staff during the study. This information may be looked at by authorized individuals from regulatory authorities, [\*\*\* insert hospital/institution name if necessary\*\*\*] or public health agencies. I agree that these individuals may have access to my research records and their study results. |  |  |
|  |
|  |  |  |
| * I understand that my information can be collected, analysed, reported and shared with others within and outside [\*\*\* insert name country/region\*\*\*] as part of this study. I understand that my name will not be used and I will not be identified.
 |  |  |
|  |  |  |
| * I agree that my family doctor should be informed of my participation in this study.
 |  |  |
|  |  |  |
| I agree to be contacted directly by the investigators with an invitation to participate in future research studies.  |  |  |
| OR IF YOU DO NOT AGREE, TICK HERE ❑ |  |  |

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Person taking consent:

(Research team member or health professional trained in taking consent for this study)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witnessed Consent**

***If the consenting party cannot read the form:*** I have no interest or involvement in this research study and I attest that the information concerning this research was accurately read and explained to the patient in language they can understand, and that informed consent was freely given by the patient.

Witness name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1 copy for patient; 1 for researcher; 1 to be kept with hospital notes/records**