

*Patient name:*

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

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

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

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

**CONSULTEE DECLARATION FORM**

**01 February 2016. Version 1.0**

|  |  |  |
| --- | --- | --- |
|  |  | **Please initial box** |
| I have been consulted about [\*\*\*insert name\*\*\*]’s participation in this research project. 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 the participant's participation is voluntary and that the participant is free to withdraw from the study at any time, without giving any reason and without the participant's medical care or rights being affected. |  |  |
|  |  |  |
| I understand that data will be collected from the participant's 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 the participant's research records and their study results. |  |  |
|  |
|  |  |  |
| I understand that the participant's family doctor should be informed that the participant is taking part in this study.  |  |  |
|  |  |  |
| * I understand that the participant's 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 the participant's name will not be used and they will not be identified.
 |  |  |
|  |  |  |
| I understand for the participant to be contacted directly by the investigators with an invitation to participate in future research studies.  |  |  |
| OR IF YOU DO NOT AGREE, TICK HERE ❑ |  |  |
|  |  |  |

Name of consultee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to participant Signature Date

Person taking consent:

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

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

Contact details of participant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Adress Phone number

**Witnessed Declaration:**

***If the consultee 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**