**Optimisation of Peri-operative Cardiovascular Management to Improve Surgical Outcome II (OPTIMISE II) Trial**

UK PATIENT CONSENT FORM

IRAS ID: 209688

Name of Principal Investigator: [Insert here]

Site Name: [Insert here] Trial ID: |\_\_||\_\_|\_\_|\_\_| -|\_\_|\_\_|\_\_|\_\_|

**Please initial box**

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| --- | --- | --- | --- | --- |
| 1. | I confirm that I have read and understand the information sheet dated DD/MMMM/YYYY (version N.N) for the OPTIMISE II trial. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily. | | |  |
| 2. | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, or my medical care or legal rights being affected. | | |  |
| 3. | I understand that sections of my medical notes and data collected during the trial may be looked at by the research team, the national or international co-ordinating centre, the sponsor (and its representatives), the regulatory authorities, or the *NHS Trust/Health Board* where it is relevant to this research. I give permission for these individuals and bodies to have access to my records. | | |  |
| 4. | I agree for the research team to contact my primary care practitioner (GP) in order to gather basic information about my health and to inform them of my involvement in this study. | | |  |
| 5. | I understand that information collected about me including my name, DOB and NHS number will be shared with NHS Digital and other central NHS bodies to provide information about my health status for this research. | | |  |
| 6. | I understand that data collected about me for this trial will be used for study analysis. I agree for my data to be securely stored and archived by Queen Mary University of London. | | |  |
| 7. | I agree for my anonymised data to be shared with other researchers for further research and research publications on this topic. | | |  |
| 8. | I agree to take part in the OPTIMISE II trial. | | |  |
| Print name of participant: | | Date: | Signature: | |
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|  | |  |  | |
| Print name of person taking consent  (designated responsible person): | | Date: | Signature: | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Print name of researcher: | | Date: | Signature: | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

***When completed, give one copy to the patient; file the original in the Investigator Site File; and place one copy in the medical notes***