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

INTERNATIONAL PATIENT CONSENT FORM

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/international equivalent [delete as appropriate]* 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 in order to gather basic information about my health and to inform them of my involvement in this study. | | |  |
| 5. | 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. | | |  |
| 6. | I agree for my anonymised data to be shared with other authenticated researchers for further research, and research publications on this topic. | | |  |
| 7. | 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: | |
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| 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***