To be printed on local hospital headed paper

Consent Form
Version ~~1.1~~1.0, ~~14 December 2020~~12 April 2022

To be completed by the Researcher:	
Hospital name:	
Trial Number:	

1. I confirm that I have read and understand the Patient Information Sheet (version X.X, dated DD/MM/20YY) for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my continued participation is voluntary, and that I am free to withdraw consent at any time, without giving any reason and without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical records and data collected during the study, held by the NHS, may be looked at by authorised individuals from the Intensive Care National Audit & Research Centre (ICNARC) or regulatory authorities to check that the study is being carried out correctly. I give permission for these individuals to have access to my records where it is relevant to my participation in this research.

4. I agree that the information held and maintained by NHS Digital and NHS Wales Informatics Service may be used to provide information about my health status. I agree that my name, date of birth, NHS number and postcode can be securely sent to ICNARC to be used for this purpose.

5. I agree to continue to participate in this research study.

OPTIONAL

	Please initial each box if in agreement
6. I understand that I may be sent a questionnaire by ICNARC in three months' time to find out how I am doing with my health. I agree for my contact details to be securely sent to ICNARC to be used for this purpose.	
7. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other approved researchers.	
8. I agree to participate in the EXAKT sub-study and for data collected for this sub-study to be securely sent to ICNARC to be used for this research.	

Name of Patient (PRINT)	Signature	Date
_____	_____	_____

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_____	_____	_____
Name of Person seeking consent (PRINT)	Signature	Date

_____	_____	_____
Name & relationship of witness *if Patient is unable to sign* (PRINT)	Signature	Date

1 copy for patient; 1 copy for Investigator Site File; 1 copy to be kept with hospital notes

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