Perioperative Quality Improvement Programme

Patient Consent Form

One copy should be given to the participant, one copy placed in their medical notes and one copy retained by the research team

PQIP
Perioperative Quality Improvement Programme

Patient Details

Surname

____

Forename

____

Date of Birth

____

To be completed by the hospital

Hospital

____

NHS number

____

Phone number (for contact on Day 3 if discharged from hospital)

____

Email address (for contact for questionnaires at 6 months and 12 months after surgery)

____

Would you prefer to be contacted by telephone or email to complete questionnaires in 6 and 12 months' time?

Phone ☐ Email ☐ Don't mind ☐

I would like to receive updates on PQIP from the study team, approximately once a year, by email:

Yes please ☐ No thanks ☐

	Please initial
1. I confirm that I have read the participant information sheet dated 16/02/2017 (version 0.8) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. If I choose to withdraw, I understand that no further information will be collected about me, but anonymous information provided may still be used for research.	☐
3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the Royal College of Anaesthetists, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
4. 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 researchers.	☐
5. I understand that the information held and maintained by NHS Digital, other central UK NHS bodies and the Office of National Statistics (or other UK Government held data) may be used to provide information about my health status.	☐
6. I agree to take part in the above study.	☐

NAME:______________________________ SIGNATURE: _________________________ DATE: ______________

To be completed by the hospital (person accepting patient consent)

Name Signature

____

Position Date

____