PQIP 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

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 questionnaires at 6 months and 12 months after surgery) _____

Would you prefer to be contacted by telephone or email to complete follow up questionnaires in 6/12 months' time? Phone ☐ Email ☐ Don't mind ☐

Would you 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 05.08.2020 (version 1.3) 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, including electronic records, 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 personal details will be shared with NHS Digital (England), NHS Wales Informatic Service (Patient Episode Database for Wales, Wales) or NHS National Services Scotland (Scotland) to obtain information held by them and the Office for National Statistics in order to provide details about my health status and hospital admissions that are not otherwise collected by the PQIP study (see patient information sheet for more details). ☐
6. I agree to take part in the above study. ☐

NAME:_____ SIGNATURE:_____ DATE: _____

To be completed by the hospital (person accepting patient consent) **Tick if consent is taken remotely** ☐

Name _____ Signature _____

Position _____ Date _____

*To be initialed by the person taking consent if being done remotely.