



	Initials
<i>I confirm that I have read and understand the BELLS Patient Information Sheet, and that I have had the opportunity to ask questions.</i>	
<i>I understand that my participation is voluntary, and that I am free to withdraw from the study at any time, without giving any reason, and without my medical care or legal rights being affected.</i>	
<i>I understand that sections of my medical notes may be looked at by responsible persons associated with the study, or by regulatory authorities where it is relevant to my taking part in the research. I give permission for these persons to have access to my records.</i>	
<i>I understand that I may be approached for follow-up information, after my final assessment visit, by responsible persons associated with the study, and I give permission for such an approach to be made.</i>	
<i>I agree to take part in the BELLS Study.</i>	

Name of patient (print)	Date	Signature
Name of person taking consent (who should witness the patient's signature)	Date	Signature