Centre Number:

Study Number:

Patient Identification Number for this study:

CONSULTEE DECLARATION FORM

Title of Project: Molecular diagnosis of hospital infection
Name of Researcher:

Please initial box

1. I ……..(name of consultee) have been consulted about …… (name of potential participant) participation in this research project. I have had the opportunity to ask questions about the study and understand what is involved . ☐

2. In my opinion, he/she would have no objection to taking part in the above study ☐

3. I understand that the participation of my relative/friend in this study is voluntary and that I am free to withdraw he/she from the study at any time, without giving any reason and without their medical care or legal rights being affected. ☐

4. I understand that relevant sections of his/her care record and data collected during the study may be looked at by responsible individuals involved in this study. In my opinion, he/she would not have objected to these individuals having access to his/her care records. ☐

5. I understand that the results of this study will be saved by us for up to 5 years to allow direct comparison with similar studies performed by others. Any saved results will remain confidential and the identity of your relative will not be revealed. ☐

| --- | --- | --- |
| Name of Consultee | Date | Signature |

Relationship to participant ----------

| --- | --- | --- |
| Person undertaking consultation (if different from researcher) | Date | Signature |

| --- | --- | --- |
| Name of researcher | Date | Signature |

I copy for consultee, 1 copy for researcher, 1 copy (original) to be kept with hospital notes