Version 1.1 Version date 02/07/2019

CONSENT BY PATIENT FOR CLINICAL RESEARCH

I, …….
Identity Card No……..……
(Name of Patient)
of ……...
(Address)
hereby agree to take part in the clinical research (clinical study/questionnaire study/drug trial) specified below:

Title of Study: The Effect of 30-Minute Mindful Breathing in Reducing Fatigue Symptom among Patients with Haematological Cancer – A Randomized Controlled Trial.

the nature and purpose of which has been explained to me by
Dr. ..……..……..……
(Name & Designation of Doctor)

and interpreted by ……..……..…..……
(Name & Designation of Interpreter)

…….. to the best of his/her ability in ……..…… language/dialect.

I have been told about the nature of the clinical research in terms of methodology, possible adverse effects and complications (as per patient information sheet). After knowing and understanding all the possible advantages and disadvantages of this clinical research, I voluntarily consent of my own free will to participate in the clinical research specified above.

I understand that I can withdraw from this clinical research at any time without assigning any reason whatsoever and in such a situation shall not be denied the benefits of usual treatment by the attending doctors.

Date: ……...…….. Signature or Thumbprint ……..……
(Patient)

IN THE PRESENCE OF

Name ……...…..……...…)
)
Identity Card No. ……..…..……) Signature

(*Witness for Signature of Patient)*
Designation ……..……)

I confirm that I have explained to the patient the nature and purpose of the above-mentioned clinical research.

Date ……. Signature ……
(Attending Doctor)

Version 1.1 Version date 02/07/2019

CONSENT BY RESPONSIBLE RELATIVE FOR CLINICAL RESEARCH

I, …….
Identity Card No……...……
(Name)
of ……
(Address)

hereby agree that my relative ……..
I.C. No……..……
(Name)
participate in the clinical research (clinical study/questionnaire study/drug trial) specified below:-
Title of Study: The Effect of 30-Minute Mindful Breathing in Reducing Fatigue Symptom among Patients with Haematological Cancer – A Randomized Controlled Trial.

the nature and purpose of which has been explained to me by Dr.
..…….……..……
(Name & Designation of Doctor)

and interpreted by ……..……..…..……
(Name & Designation of Interpreter)

…… to the best of his/her ability in ……..…… language/dialect.

I have been informed of the nature of this clinical research in terms of procedure, possible adverse effects and complications (as per patient information sheet). I understand the possible advantages and disadvantages of participating in this research. I voluntarily give my consent for my relative to participate in this research specified above.

I understand that I can withdraw my relative from this clinical research at any time without assigning any reason whatsoever and in such situation, my relative shall not be denied the benefits of usual treatment by the attending doctors. Should my relative regains his/her ability to consent, he/she will have the right to remain in this research or may choose to withdraw.

Date: …….. Relationship to Patient …… Signature or Thumbprint ……

IN THE PRESENCE OF

Name ……..…..)
)
Identity Card No. …….) Signature ……
) (*Witness)*
Designation ……)

I confirm that I have explained to the patient's relative the nature and purpose of the above-mentioned clinical research.

Date ……. Signature
……
(Attending Doctor)