SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Parma

UNIVERSITÀ
DI PARMA

Integrated Care Department of Mental Health and Addiction Services
University-Affiliated Hospital Psychiatric Services Unit

Consent Form

Obsessive-Compulsive Disorder: Formal and Content Modalities, Factors Involved in Loss of Insight, Role of Trauma, and Correlations with Schizophrenia Spectrum Disorders

I, the undersigned, ……
born **:** …… on ……., declare that I have received from Dr. …… on the date ……. thorough explanations regarding the request to participate in the above-mentioned study, as outlined in the attached information sheet, a copy of which was given to me on **…… .**

Based on the information received, I declare:

- ☐ That I have been informed about the purpose, procedures, and duration of this study, as well as the possible benefits and inconveniences, and I agree to participate in this study promoted by AUSL of Parma – Integrated Care Department for Mental Health and Pathological Addictions, Hospital Psychiatric Services with University Management.
- ☐ That I have been provided with a summary of the information regarding the characteristics of the study, that I have been able to discuss these explanations, to ask all the questions I deemed necessary, and that I have received satisfactory answers.
- ☐ That I am aware that I am free to refuse to participate in the study and that I can withdraw my consent at any time during the course of the study.
- ☐ That my participation in the study is entirely voluntary.
- ☐ That I have been informed and I consent to my data being made available not only to the study investigators and their delegates, but also to national and international Health Authorities, and to the Ethics Committee, if requested; and I

have also been informed that my data may be disclosed at national and international scientific conferences or published for scientific purposes in national and international medical journals, but that in any case, my identity will be protected by confidentiality (i.e., the data will always be used in ANONYMOUS and AGGREGATED form).

- I have also been informed of my right to have free access to the documentation related to the study and to the evaluation expressed by the Ethics Committee.
- To Consent □ / Not consent □ to my General Practitioner (GP) being informed.
- That I have been given a copy of this consent form to keep.
- By signing this form, I □ Consent / □ Do not consent to participate in the above-mentioned study.

Patient's Full Name: ……

Date: ……

Patient's Signature: ……

Physician's Full Name: ……

Date: ……

Physician's Signature: ……..