THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center

Informed Consent

INFORMED CONSENT/AUTHORIZATION FOR PARTICIPATION IN RESEARCH

Additive value of EBUS TBNA for Staging Non-Small Cell Lung Cancer in Patients Evaluated for Stereotactic Body Radiation Therapy
2015-0615

Study Chair: George A. Eapen

_____ _____
Participant's Name Medical Record Number

This is an informed consent and authorization form for a research study. It includes a summary about the study. A more detailed description of procedures and risks is provided after the summary.

STUDY SUMMARY

The goal of this clinical research study is to compare the results of EBUS-TBNA with the results of PET/CT scans to learn about the accuracy of these ways to find evidence of early stage lung cancer.

This is an investigational study involving collection of data from your medical record.

Future patients may benefit from what is learned. There are no benefits for you in this study.

Your participation is completely voluntary. Before choosing to take part in this study, you should discuss with the study team any concerns you may have, including potential expenses and time commitment.

You can read a list of potential side effects below in the Possible Risks section of this consent.

Your active participation in this study will be over after your tissue samples are collected by EBUS-TBNA. Your medical information will continue to be collected as long as you are coming for follow-up visits.

You and/or your insurance provider will be responsible for the cost of the EBUS-TBNA.

You may choose not to take part in this study.

1. STUDY DETAILS

Up to 150 participants will be enrolled in this study. All will take part at MD Anderson.

If you agree to take part in this study, as a part of your standard-of-care, you will have an EBUS-TBNA before SBRT. You will receive a separate consent for this that will explain the procedure and the risks.

The results from EBUS-TBNA will be tested and compared with the results of your standard PET/CT scans.

Follow-Up
As a part of your standard-of-care, after SBRT you will have follow-up exams.

Your medical information from these follow-up visits will be collected for this study. All the information for the study will be stored in a password-protected system.

2. POSSIBLE RISKS

There are no expected risks from taking part in this study.

This study may involve unpredictable risks to the participants.

3. COSTS AND COMPENSATION

By signing this consent form, you are not giving up any of your legal rights.

There are no plans to compensate you for any patents or discoveries that may result from your participation in this research.

You will receive no compensation for taking part in this study.

Additional Information

4. You may ask the study chair (Dr. George A. Eapen, at 713-563-4256) any questions you have about this study. You may also contact the Chair of MD Anderson's Institutional Review Board (IRB - a committee that reviews research studies) at 713-792-6477 with any questions that have to do with this study or your rights as a study participant.

5. You may choose not to take part in this study without any penalty or loss of benefits to which you are otherwise entitled. You may also withdraw from participation in this study at any time without any penalty or loss of benefits. If you decide you want to stop taking part in the study, it is recommended for your safety that you first talk to your doctor. If you withdraw from this study, you can still choose to be treated at MD Anderson.

6. This study or your participation in it may be changed or stopped without your consent at any time by the study chair, the U.S. Food and Drug Administration (FDA), the Office for Human Research Protections (OHRP), or the IRB of MD Anderson.

7. You will be informed of any new findings or information that might affect your willingness to continue taking part in the study, and you may be asked to sign another informed consent and authorization form stating your continued willingness to participate in this study.

8. MD Anderson may benefit from your participation and/or what is learned in this study.

Future Research

Data
Your personal information is being collected as part of this study. These data may be used by researchers at MD Anderson and/or shared with other researchers and/or institutions for use in future research.

Authorization for Use and Disclosure of Protected Health Information (PHI):

A. During the course of this study, MD Anderson will be collecting and using your PHI, including identifying information, information from your medical record, and study results. For legal, ethical, research, and safety-related reasons, your doctor and the research team may share your PHI with:
   - Federal agencies that require reporting of clinical study data (such as the FDA, National Cancer Institute [NCI], and OHRP)
   - The IRB and officials of MD Anderson
   - Study monitors and auditors who verify the accuracy of the information
   - Individuals who put all the study information together in report form

Study sponsors and/or supporters receive limited amounts of PHI. They may also view additional PHI in study records during the monitoring process. MD Anderson's contracts require sponsors/supporters to protect this information and limit how they may use it.

B. Signing this consent and authorization form is optional but you cannot take part in this study or receive study-related treatment if you do not agree and sign.

C. MD Anderson will keep your PHI confidential when possible (according to state and federal law). However, in some situations, agencies to which your PHI was disclosed could be required to reveal the names of participants.

Once disclosed outside of MD Anderson, federal privacy laws may no longer protect your PHI.

D. The permission to use your PHI will continue indefinitely unless you withdraw your authorization in writing. Instructions on how to do this can be found in the MD Anderson Notice of Privacy Practices (NPP) or you may contact the Chief Privacy Officer at 713-745-6636. If you withdraw your authorization, you will be removed from the study and the data collected about you up to that point can be used and included in data analysis. However, no further information about you will be collected.

CONSENT/AUTHORIZATION

I understand the information in this consent form. I have had a chance to read the consent form for this study, or have had it read to me. I have had a chance to think about it, ask questions, and talk about it with others as needed. I give the study chair permission to enroll me on this study. By signing this consent form, I am not giving up any of my legal rights. I will be given a signed copy of this consent document.

_____ _____
SIGNATURE OF PARTICIPANT DATE

_____
PRINTED NAME OF PARTICIPANT

WITNESS TO CONSENT

I was present during the explanation of the research to be performed under Protocol 2015-0615.

_____ _____
SIGNATURE OF WITNESS TO THE VERBAL CONSENT PRESENTATION (OTHER THAN PHYSICIAN OR STUDY CHAIR) DATE

A witness signature is only required for vulnerable adult participants. If witnessing the assent of a pediatric participant, leave this line blank and sign on the witness to assent page instead.

_____
PRINTED NAME OF WITNESS TO THE VERBAL CONSENT

PERSON OBTAINING CONSENT

I have discussed this research study with the participant and/or his or her authorized representative, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks and that the participant understood this explanation.

_____ _____
PERSON OBTAINING CONSENT DATE

_____
PRINTED NAME OF PERSON OBTAINING CONSENT