The Effect of Perıoperative Heated Sock Use in Preventing Hypothermia During Total Hip Prosthesis Surgery: A Randomized Controlled Trial

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You have been invited to participate in a study titled "The Effect of Perioperative Heated Sock Use in Preventing Hypothermia During Total Hip Prosthesis Surgery: A Randomized Controlled Trial." The reason for this invitation is your medical history involving total hip replacement surgery.

Participation in this study is voluntary and you will be fully informed about the research before making a decision to participate. Dr. Hem. Seval ULUBAY is responsible for this study, which will be conducted at Samsun Gazi State Hospital's general surgery department.

Here are the details about the study:

- **Study Objective**: The aim of the study is to investigate the effect of perioperative heated sock use in preventing hypothermia during total hip prosthesis surgery.
- **Number of Participants**: The study plans to include patients who meet the inclusion criteria and voluntarily agree to participate during the study period at the orthopedic clinic of Samsun Gazi State Hospital. The sample size was calculated to be 70 participants using the G-power program, considering an effect size index of d=0.70, α=0.05 (error margin), and 1-β=0.95 (power) (Amiri, M., Mirzaei, S., & Nasiriani, K., 2021).
- **Study Design**: The research will be conducted as a single-center study at Samsun Gazi State Hospital.

Should I participate in this study?

Participation in this study is entirely voluntary. Even if you sign this form now, you are free to withdraw from the study at any time without needing to provide a reason.

Are there any risks or discomforts associated with participating in the study?

There are no risks or discomforts associated with participating in this study.

What are the costs of participating in this study?

There are no costs associated with participating in this study, and you will not receive any payment.

How will my personal information be used?

Your personal information will be used by your doctor for conducting the research and statistical analysis. However, your identity will be kept confidential. Only if necessary, information about you may be reviewed by ethics committees or government authorities. At the end of the study, you have the right to request information about your own results. Study results may be published in medical literature, but your identity will not be disclosed.

Who can I contact for more information?

If you need more information about the study, please contact:

- **Name**: Seval ULUBAY
- **Position**: Dr. Hem.

- **Phone**: 05424300793

(Participant/Patient Declaration)

I have been informed about the details provided above regarding this research conducted by Dr. Seval ULUBAY at the orthopedic clinic. I have read and understood the information presented to me. I have not faced any coercive behavior regarding my participation in this study. I understand that I am free to decline participation, and that declining will not affect my medical care or relationship with my physician in any way. I also understand that I can withdraw from the study at any time without needing to provide a reason, though it would be appropriate to inform the researchers in advance to avoid putting them in a difficult situation. Additionally, I understand that I may be excluded from the study for reasons related to my medical condition, provided that no harm will be caused to my health. I am not assuming any financial responsibility related to the expenses of the research, and I will not receive any payment. I am aware that the confidentiality of my personal information obtained from the study will be maintained. I have been assured that any health problems arising from the study will be addressed with necessary medical interventions, without any financial obligation on my part related to these medical interventions.

I have understood all the explanations provided in detail. I voluntarily agree to participate in this clinical research under these conditions, without any pressure or coercion.

A signed copy of this form will be provided to me.

[Signature]
[Date]

Participant Name,

Surname:

Address:

Phone:

Signature:

Date:

Witness Name,

Surname:

Address:

Phone:

Signature:

Date:

Doctor who consulted with the participant Name,

Title:

Address:

Phone:

Signature:

Date: