

INFORMED CONSENT FORM

LIPID - LOWERING REGIMES IMPROVE OXIDATIVE STRESS, TRYPTOPHAN DEGRADATION IN HYPERCHOLESTEROLEMIA CKD PATIENTS

Date of review: 03th May, 2018

This is a research on health care, carried out by Doctor from Hue University of Medicine and Pharmacy. I understand that this research has been approved by Ethnic Committee of Hue University of Medicine and Pharmacy. Subjects of the research is: "Lipid - lowering regimes improve oxidative stress, Tryptophan degradation in hypercholesterolemia CKD patients"

The researcher should have the patient read this form carefully and answer any questions the patient may have. Before the research can start, the researcher and the patient should sign two copies of this form. The patient will be given one copy of the signed form.

1. Consent for participation in research, I volunteer to participate in a research project conducted by Doctor..... I understand that I will be one of 30 people being participated in this research. I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty.
2. I will be randomly prescribed lipid-lowering therapy by the researcher in 12 months. I understand that there may be some side effects related to drugs such as muscle pain, muscle weakness, elevate hepatic enzyme,...My blood samples will be taken during the research, at baseline and 4, 8, 12 months of treatment.
3. I have to visit the clinic monthly for treatment and side effects monitoring.
4. My personal information and the research results related to me will be kept in secrete, not to be sent to my office and family without my permission.
5. For research problems, Doctor..... may contact me through my information of the contact person. And I can contact her anytime if I have any questions or problems involved in research.
6. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

For further information, please contact: Doctor..... Tel:

Date _____

My Signature _____

Researcher Signature _____