



Informed Consent

INFORMED CONSENT/AUTHORIZATION FOR PARTICIPATION IN RESEARCH

Validation of a Multi-Parametric Ultra-high Field MRI Protocol for Central
Nervous System Malignancy

2019-1032

Study Chair: Max Wintermark, MD

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.

This research has been reviewed and approved by an Institutional Review Board (IRB - a committee that reviews research studies).

STUDY SUMMARY

The goal of this clinical research study is to learn if a new MRI system can provide better quality images than a standard MRI. The name of the new system is the MRI 7 Tesla (MRI 7T).

This is an investigational study. The MRI 7T system is FDA approved for brain imaging and brain cancer screening. The group of advance imaging techniques using the MRI 7T is considered investigational.

Future patients may benefit from what is learned on this study. There are no direct 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 side effects, potential expenses, and time commitment.

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

Your participation in this study will be over after the research MRI 7T scan is complete.

The research MRI 7T scan of the head will be performed at no cost to you.

You may choose not to take part in this study. Instead of taking part in this study, you may choose to receive a standard of care MRI scan of the head without taking part in this study.

1. STUDY DETAILS

Up to 100 participants will be enrolled in this study. All patients enrolled will take part at MD Anderson.

The imaging will be performed at the Houston Methodist Research Institute (HMRI). Although HMRI follows all national and local recommendations to minimize the risk of COVID transmission, participating in this research scan does raise the potential risk of exposure to COVID-19.

If you agree to take part in this study, you will have a research MRI 7T scan. The whole procedure is similar to a standard MRI and may take up to 60 minutes.

You will be asked to complete a short questionnaire about your experience in the MRI 7T system after the scan is complete. The questionnaire should take about 5-10 minutes.

2. POSSIBLE RISKS

While on this study, you are at risk for side effects. You should discuss these with the study doctor. The known side effects are listed in this form, but they will vary from person to person.

During the **MRI**, you may feel mild vibrations throughout your body. The machine will produce a loud knocking noise. This is normal. You will be given earplugs to protect your ears. Some people, especially those who tend to feel uncomfortable in small or closed spaces, may feel “closed in” and become anxious while in the scanner. The scanner has an intercom, which will allow you to speak to the staff during the procedure. If you feel ill or anxious during scanning, tell the MRI staff and the scanning will be stopped if you wish. The MRI will require a catheter to be inserted into one of your veins in order to inject the MRI contrast agent. This may cause skin irritation, bleeding, and/or infection. You may have an allergic reaction to the contrast agent.

The magnetic field used in MRI scanning may harm you if you have certain types of metal in your body (as might be found in pacemakers, neurostimulators, or certain clips). It may cause problems with devices, such as pacemakers. If you have metal in your body or devices such as a pacemaker, you should discuss this with the study doctor.

Most patients do not notice a difference between a standard MRI and the MRI 7T. You may experience a short spell of dizziness after entering the scanner.

Questionnaires may contain questions that are sensitive in nature. Some questions may make you feel upset or uncomfortable. You may refuse to answer any question. If you have concerns after completing the questionnaire(s), you are encouraged to contact your doctor or the study chair.

Although every effort will be made to keep study data safe, there is a chance that your personal health information could be lost or stolen, which may result in a **loss of confidentiality**. All study data will be stored in password-protected computers and/or locked file cabinets and will continue to be stored securely after the study.

This study may involve unpredictable risks to the participants.

3. COSTS AND COMPENSATION

If you suffer injury as a direct result of taking part in this study, MD Anderson health providers will provide medical care. However, this medical care will be billed to your insurance provider or you in the ordinary manner. You will not be reimbursed for expenses or compensated financially by MD Anderson for this injury. You may also contact the Chair of MD Anderson's IRB at 713-792-6477 with questions about study-related injuries. By signing this consent form, you are not giving up any of your legal rights.

Certain tests, procedures, and/or drugs that you may receive as part of this study may be without cost to you because they are for research purposes only. However, your insurance provider and/or you may be financially responsible for the cost of care and treatment of any complications resulting from the research tests, procedures, and/or drugs. Standard medical care that you receive under this research study will be billed to your insurance provider and/or you in the ordinary manner. Before taking part in this study, you may ask about which parts of the research-related care may be provided without charge, which costs your insurance provider may pay for, and which costs may be your responsibility. You may ask that a financial counselor be made available to you to talk about the costs of this study.

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

You will receive a parking validation ticket when you have the study research MRI scan at the Methodist Hospital as compensation for taking part in this study.

Additional Information

4. You may ask the study chair (Dr. Max Wintermark, at 713-792-0485) 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 who will decide if you need to have any visits or tests to check on your health. If you withdraw from this study, you can still choose to be treated at MD Anderson.

If you stop being in the research, already collected data may not be removed from the study database. You may be asked whether the study doctor can collect data from your routine medical care. If you agree, this data will be handled the same as research data.

6. This study or your participation in it may be changed or stopped without your consent at any time by the study chair, MD Anderson, the U.S. Food and Drug Administration (FDA), the Office for Human Research Protections (OHRP), or the IRB of MD Anderson. Possible reasons your participation in this study may be stopped include if you are unable to follow study directions or if the study is stopped.
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 Houston Methodist Hospital, and/or shared with other researchers and/or institutions for use in future research.

If identifiers are removed from your identifiable private information that is collected during this research, that information could be used for future research studies or shared with another researcher for future research studies without your additional informed consent.

In some cases, all of your identifying information may not be removed before your data are used for future research. If future research is performed at MD Anderson, the researchers must get approval from the Institutional Review Board (IRB) of MD Anderson before your data can be used. At that time, the IRB will decide whether or

not further permission from you is required. The IRB is a committee of doctors, researchers, and community members that is responsible for protecting study participants and making sure all research is safe and ethical.

If this research is not performed at MD Anderson, MD Anderson will not have oversight of any data.

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
- MD Anderson, who is a sponsor or supporter of this study, and/or any future sponsors/supporters of the study
- Houston Methodist Hospital
- 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.

Your MRI images will be returned to MD Anderson by a secure file transfer method for review and analysis.

The results of this research may be published in scientific journals or presented at medical meetings, but your identity will not be disclosed.

- 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, the FDA 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.
- E. A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.
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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**LEGALLY AUTHORIZED REPRESENTATIVE (LAR)**

The following signature line should only be filled out when the participant does not have the capacity to legally consent to take part in the study and/or sign this document on his or her own behalf.

SIGNATURE OF LAR

DATE

PRINTED NAME and RELATIONSHIP TO PARTICIPANT**WITNESS TO CONSENT**

I was present during the explanation of the research to be performed under this protocol.

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

DATE

A witness signature is only required for non-English speakers utilizing the short form consent process (VTPS) and patients who are illiterate.

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

PARENT/GUARDIAN PERMISSION

I have read and understand the description of this research. I have had a chance to discuss the study and ask questions. My questions have been answered. I give permission for my child or ward to take part in this study.

SIGNATURE OF PARENT/GUARDIAN

DATE

PRINTED NAME OF PARENT/GUARDIAN

SIGNATURE OF PARENT/GUARDIAN

DATE

Signature of Other Parent (Optional, unless required by the IRB.)

PRINTED NAME OF PARENT/GUARDIAN

____ The IRB has determined that the signature of both parents is required.

If not obtaining both parental signatures, please indicate reason below:

____ Other parent is deceased, unknown, incompetent, or not reasonably available.

____ Parent/Guardian signing above has sole legal responsibility for the care and custody of the child.

____ The IRB has determined that the signature of both parents is NOT required.

ASSENT OF MINOR

(Entire section must be completed if the participant's intellectual age is at least 7 and less than 18 years. Participants with an intellectual age of 7 - 12 are not required to sign.)

If written assent is not obtained on an age-appropriate participant, check reason why not:

____ 1.) The participant's intellectual age is less than seven.

____ 2.) The participant dissented, but the participant's parent(s)/guardian felt that the intervention(s) or procedure(s) involved in the research hold out the possibility of a direct benefit that is important to the health and/or well being of the participant and is available only in the context of this research study.

____ 3.) Other: _____

I have been told what I will be asked to do in this study.

I have been told that I do not have to be in this study. If I decide not to be in this study, no one will be mad at me. I may quit at any time, but if I do, I may need to take a different treatment.

I have had a chance to talk about the study and ask the study doctor questions. All of my questions have been answered. I agree to be in this study and do what I am asked to do so long as I want to stay in this study. I agree that the study doctor can put me on this study. By signing this paper, I am not giving up any of my legal rights. I have been given a copy of this document.

SIGNATURE OF MINOR (Age 13-17)

DATE

PRINTED NAME OF MINOR

TRANSLATOR

I have translated the above informed consent as written (without additions or subtractions) into _____ and assisted the people

(Name of Language)

obtaining and providing consent by translating all questions and responses during the consent process for this participant.

NAME OF TRANSLATOR

SIGNATURE OF TRANSLATOR

DATE

☐ Please check here if the translator was a member of the research team. (If checked, a witness, other than the translator, must sign the witness line.)