Blackpool Teaching Hospitals NHS
NHS Foundation Trust

INFORMED CONSENT FORM

Version 4.0 – 07/11/2018

Patient Research Identification Number:

Name of Researcher: Robyn Jones

Title of Research: **Orthoglide Study (**IRAS Project ID: **235931)**

Please Initial box

I confirm that I have read and understand the information sheet dated the 07/11/2018 (version 4.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the research team, sponsor (UCLan), regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I understand that the research team and all other individuals involved in this project are bound by strict confidentiality and data protection laws including the General Data Protection Regulations (2018) and will only access information required for this study from my medical records, specifically the date of my planned surgery, my GP and contact details.

I agree to take part in the above study which includes being contacted by telephone before my surgery, 6 weeks afterwards and again at 12 weeks, with each conversation taking around 25 minutes.

I agree that I will adhere to the rehabilitation exercises prescribed to me by the Physiotherapy team.

Once analysed and written would you like to receive a copy of the results of this study? Please select the appropriate box below:

Yes No

If you selected 'yes' how would you like the results to be sent to you? Please select from the options below:

By Email

By Post

Please provide the email/postal address you would like the results sent to:
……
……
……

Name of Patient	Date	Signature

Preferred contact number of patient

……..

Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.