THE UNIVERSITY OF MELBOURNE

ID: _ _/_ _
Date: _ _/_ _/_ _

Department of General Practice, University of Melbourne

CONSENT FORM FOR PATIENTS

Project title: The CRISP trial: assessing bowel cancer risk in general practice.

Name of participant: ____

Name of investigator(s):
Prof Jon Emery, A/Prof Marie Pirotta, Dr Jennifer Walker, Ms Sibel Saya, Ms Jasmeen Oberoi, Ms Kitty Novy, and Ms Shakira Milton on behalf of the CRISP investigators

1. I consent to take part in this research project, the details of which have been explained to me, and I have been provided with a written participant information form (Participant Information Statement Version 5, 15_September_2017) to keep.
2. I understand that after I sign and return this consent form it will be retained by the researcher.
3. I understand that my participation will involve a computer based questionnaire (if in the intervention group) and I agree that the researchers may use the results as described in the participant information form.
4. I allow the release of my medical information from my medical records including general practice, Medicare, the National Bowel Cancer Screening Program and Victorian Hospital data that relates to previous screening for bowel cancer and during the next 5 years.
5. I acknowledge that:
   a. The possible effects of participating in the questionnaire and computer based program (if in the intervention group) have been explained to my satisfaction;
   b. I understand that my involvement in this study is entirely voluntary;
   c. I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;
   d. The project is for the purposes of research;
   e. I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
   f. I have been informed that my consent form and information will be stored securely at the University of Melbourne and destroyed after 5 years;
   g. My name will not be identified in any publications arising from the research;
   h. I have been informed that a copy of the research findings will be forwarded to me, should I request it at the completion of the study;
   i. In accordance with the law of Victoria, I understand that it is possible for data to be subject to subpoena, or freedom of information request.

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6. I understand my consultation might be video-recorded and that this is voluntary. The video recording will only be used for research purposes and my choice not to be video-recorded will not be disclosed to anyone except the research team.

Please tick one box: ☐ I consent to be video-recorded ☐ I do not consent to be video-recorded

7. I consent to the research team contacting me for a follow up telephone interview about my experience of being involved in the study. The interview will be recorded but is optional. The number I can be contacted on is below:

Contact number: ____

Preferred method for follow up surveys:

◯ online survey

(email address) ____

◯ postal survey

(mailing address)

Name: ____

Street: ____

Suburb: ____

State: ___________________ Postcode: _____________________________

Participant signature: _______________________________________ Date: ___________

Researcher's Name (printed) _________________________________ Date: ___________

Signature: ____ Date: ___________

Please complete the following pages to allow the release of your Medicare data, National Bowel Cancer Screening data and data from the Department of Health and Human Services, Victoria.

We will only access data that relates to screening for bowel cancer during the next 5 years and the previous 4 ½ years.

This study has been funded by the Australian National Health and Medical Research Council [APP1042021] and the Victorian Cancer Agency [HSR15019].

Participant ID:

PARTICIPANT CONSENT FORM

Consent to release of Medicare claims information for the purposes of **The CRISP trial: assessing risk of bowel cancer in general practice.**

Important Information
Complete this form to request the release of personal Medicare claims information to **The CRISP trial: assessing risk of bowel cancer in general practice.**

Any changes to this form must be initialled by the signatory. Incomplete forms may result in the study not being provided with my information.

By signing this form, I acknowledge that I have been fully informed and have been provided with information about this study. I have been given an opportunity to ask questions and understand the possibilities of disclosures of my personal information.

PARTICIPANT DETAILS

1. Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name: ________________________________First given name:_________________________

Other given name (s): __________________________

Date of birth: DD / MM / YYYY

2. Medicare card number: ______________________

3. Permanent address: ____

Postal address (if different to above): ____

AUTHORISATION

4. I authorise Department of Human Services to provide my:

☐ Medicare claims history

for the period* DD / MM / YYYY to: DD / MM / YYYY to the CRISP trial.

*Note: The Department of Human Services can only extract 4 ½ years of data (prior to the date of extraction). The consent period above may result in multiple extractions.

DECLARATION

I declare that the information on this form is true and correct.

5. Signed: ____________________ (participant's signature) Dated: DD / MM / YYYY OR

6. Signed by: ____________________ (full name) _________________ (signature) on behalf of participant

Dated: DD / MM / YYYY

☐ Power of attorney* ☐ Guardianship order*

*Please attach supporting evidence

APP 5 – PRIVACY NOTICE

Your personal information is protected by law, including the Privacy Act 1988, and is collected by the Australian Government Department of Human Services. The collection of your personal information by the department is necessary for administering requests for statistical and other data.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at humanservices.gov.au/privacy or by requesting a copy from the department.

Power of attorney – a power of attorney is a document that appoints a person to act on behalf of another person who grants that power. In particular, an enduring power of attorney allows the person to act on behalf of another person even when that person has become mentally incapacitated. The powers under a power of attorney may be unlimited or limited to specific acts.

Guardianship order – a guardianship order is an order made by a Guardianship Board/Tribunal that appoints a guardian to make decisions for another person. A Guardianship order may be expressed broadly or limited to particular aspects of the care of another person.

A sample of the information that may be included in your Medicare claims history:

Date of service	Date of processing	Item number	Item description	Provider charge	Schedule Fee	Benefit paid	Patient out of pocket
20/04/09	03/05/09	00023	Level B consultation	$38.30	$34.30	$34.30	$4.00
22/06/09	23/06/09	11700	ECG	$29.50	$29.50	$29.50	

Date of referral	Ordering Provider postcode	Provider derived major speciality	Item category
		General Practitioner	1
20/04/09	2302	Cardiologist	2

PARTICIPANT CONSENT FORM- Previous 4 ½ Years

Consent to release of data from the Victorian Admitted Episodes Dataset (VAED) related to colonoscopy or bowel cancer for the purposes of **The CRISP trial: assessing risk of bowel cancer in general practice.**

Important Information

Complete this form to request the release of personal VAED information to **The CRISP trial: assessing risk of bowel cancer in general practice.**

Any changes to this form must be initialled by the signatory. Incomplete forms may result in the study not being provided with my information.

By signing this form, I acknowledge that I have been provided with information about this study. I have been given an opportunity to ask questions and have been fully informed about this study.

PARTICIPANT DETAILS

1. Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other [ ]

Family name: ___________________________First given name: ____________________

Other given name (s): ______________________

Date of birth: ___/___/_____

2. Medicare card number: ___________________

3. Permanent address: ____

Postal address (if different to above): ______________________________________

AUTHORISATION

4. I authorise the Department of Health and Human Services to provide my:
medical details regarding hospital visits for the period* ___/___/_____ to: ___/___/_____ to the **The CRISP trial: assessing risk of bowel cancer in general practice**.

*Note: This period cannot exceed 4 ½ years

DECLARATION

I declare that the information on this form is true and correct.

5. Signed: ___________________ (participant's signature)

PARTICIPANT CONSENT FORM- Next 5 Years

Consent to release of data from the Victorian Admitted Episodes Dataset (VAED) related to colonoscopy or bowel cancer for the purposes of **The CRISP trial: assessing risk of bowel cancer in general practice.**

Important Information

Complete this form to request the release of personal VAED information to **The CRISP trial: assessing risk of bowel cancer in general practice.**

Any changes to this form must be initialled by the signatory. Incomplete forms may result in the study not being provided with my information.

By signing this form, I acknowledge that I have been provided with information about this study. I have been given an opportunity to ask questions and have been fully informed about this study.

PARTICIPANT DETAILS

1. Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other [ ]

Family name: ________________________________First given name: _____________________

Other given name (s): __________________________

Date of birth: ___/___/_____

2. Medicare card number: ______________________

3. Permanent address: ____

Postal address (if different to above): ____

AUTHORISATION

4. I authorise the Department of Health and Human Services to provide my:
medical details regarding hospital visits for the period* ___/___/_____ to: ___/___/_____ to the **The CRISP trial: assessing risk of bowel cancer in general practice**.

*Note: This period cannot exceed 4 ½ years

DECLARATION

I declare that the information on this form is true and correct.

5. Signed: ______________________ (participant's signature)

PARTICIPANT CONSENT FORM- Next 5 Years

Consent to release of data from the Victorian Admitted Episodes Dataset (VAED) related to colonoscopy or bowel cancer for the purposes of **The CRISP trial: assessing risk of bowel cancer in general practice.**

Important Information

Complete this form to request the release of personal VAED information to **The CRISP trial: assessing risk of bowel cancer in general practice.**

Any changes to this form must be initialled by the signatory. Incomplete forms may result in the study not being provided with my information.

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