##



**Participant Consent Form - Patients**

**COPING:** **CO**gnitive impairment in **P**eople with glioma and distress in their **IN**formal care-**G**ivers

Version #1: 12/03/19

By giving my consent I confirm that:

I have read the Participant Information Sheet (Version #1: 12/03/19) for the above research project. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.

I have had an opportunity to discuss this study with someone like family or friends to support me choose whether or not I would like to participate, and how I might feel about my continued participation in the event that my capacity to consent varies or is lost in the future.

I understand that members of my healthcare team will be aware of my decision to participate or not to participate in this study and that my decision to participate or not participate will not affect my medical treatment or my relationship with the staff who are caring for me.

I understand that my participation in this study will allow the research team to access my medical record and I agree to this.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my medical care, relationship with the staff who are caring for me, or legal rights being affected.

I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I agree to take part in the above research project.

In the event that my capacity to consent varies or is lost in the future while I am still a participant in this study, I would like to:

 🞏 Be withdrawn from the study

 🞏 Continue participating in the study so long as I appear comfortable with doing so, and unless my healthcare team feel that this would be contrary to my best interests

Please provide contact details:

|  |
| --- |
| **Address:** |
| **Suburb:** **State:**  **Postcode:** |
| **Telephone number:** |
| **Email:** |

**Participant Name:**

**Signature Date**

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***PLEASE COMPLETE OTHER SIDE***

I would like a copy of the research project’s results sent to me when available. I understand that my name and contact details will be provided to the University of Newcastle for this purpose.

 🞏 Yes via email 🞏 Yes via post 🞏 No

*Heatlhcare professional only:*

After discussion with the above named participant, I agree that the patient has the capacity to give free and informed consent to this study.

**Name:**

**Signature Date**

***Please return form in the enclosed pre-paid envelope.***