**Attachment E**

**GP CONSENT FORM**

**Study Title:** **C**linical and **H**ealthcare **I**mprovement through **M**y Health Record usage and **E**ducation in **G**eneral **P**ractice – The CHIME-GP Study

**INVESTIGATORS**

|  |  |
| --- | --- |
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| A/Prof Judy Mullan | Graduate Medicine, University of Wollongong, 2522 |
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I have been given information about the research project **C**linical and **H**ealthcare **I**mprovement through **M**y Health Record usage and **E**ducation in **G**eneral **P**ractice – The CHIME-GP Study - and have been provided the opportunity to discuss the research withthe investigators who are conducting this research.

I have been advised of any possible risks or burdens associated with this research and have had the opportunity to ask the investigatorsany questions I may have about the research and my participation.

I understand my participation is voluntary, I am free to refuse to participate and I am free to withdraw from the research at any time. My refusal to participate or withdraw consent will not affect my relationship with the researchers, the University of Wollongong, Medcast or PenCS.

I understand that if I choose to participate in this study, I will be asked to:

* Be randomly allocated to a prescribing, pathology or radiology education arm of the study
* Potentially participate in a 30 minute interview before the commencement of your project and at the end of your project which will be audio recorded and transcribed by a professional transcription service. (Only a selection of participants will be asked to do this)
* Complete an online pre and post intervention survey (approximately 15 minutes each)
* Participate in three live educational webinars (45 - 60 min each) – concerning prescribing, radiology or imaging
* Complete an online education module ( 60 minutes) – concerning prescribing, radiology or imaging
* Have data concerning education session uptake collected
* Provide by automated extract from my electronic health records de-identified prescribing, pathology and imaging ordering data for six months prior to and following the education sessions

I understand that any data that I provide or the researchers extract from the study for use in reports will not, under any circumstances, contain names or identifying characteristics. Any information provided is confidential, and no information that could lead to the identification of any individual or practice will be disclosed in any reports on the project, or to any other party.

By agreeing to be part of this study, I consent to:

1. PenCS extracting de-identified patient demographic and clinical data (to the extent that the University requires for use in the study as outlined in the Participant Information Sheet) via PenCS’ CAT Plus – CAT 4; and
2. This data being used for the purposes of the study, including by the University and its research collaborators.

I understand the research data will be stored securely by the University.

**By signing below I am indicating my consent to participate in the research.**

Signed by GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CAT 4 username: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

GP Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP MBS provider number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP PBS prescriber number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to be contacted regarding participation in pre-and post-education session interviews

Yes / No (Please indicate) Preferred contact regarding interview:

🞎 Prefer Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Prefer Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Prefer Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please ask you Practice Manager to return all GP consent forms in a bundle with your Practice Consent Form to UOW. Return details are provided on the Practice Consent Form.**