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| **High flow nasal oxygen for patients undergoing elective major abdominal Surgery (PROTECT-HFNO) Trial**  **PARTICIPANT INFORMED CONSENT FORM** | |
| **IRAS:** 350757 | **Name of Principal Investigator:** *[insert PI name]* |
| **Site Name:** *[insert site name]* | **Study ID:** *[insert participant’s trial ID]* |
| **How was consent received (please tick one box):** face to face remote (e.g. email or post) | |

**Please read each statement and if you agree, put your initials in the box next to it.**

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| 1. I confirm that I have read and understood the **Participant Information Sheet** version x.x dated DD/MM/YYYY for the PROTECT-HFNO Trial. I have had time to think about the information, ask questions, and I am satisfied with the answers I have been given. | Initial |
| 1. 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. | Initial |
| 1. I agree to take part in the PROTECT-HFNO trial. | Initial |
| 1. **Optional:** I wish to be contacted by *email/post (delete as applicable)* with a summary of the findings from the PROTECT-HFNO trial. My preferred contact email or postal address for this is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Initial |

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| Print Name of participant | Date | Signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Print Name and role of person taking consent (Designated responsible person) | Date | Signature |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**If a participant is unable to read or sign this consent form but has capacity to give consent, please complete the following section.**

Witness Statement (if applicable):

The participant was unable to read or sign this consent because of the following reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I confirm that I was present as a witness to this consent process. I confirm that the participant named above was read the information in the consent document and freely gave their consent to take part in the research trial.

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| Name and role of witness | Date | Signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |