NHS Grampian

Intensive Care Unit
Aberdeen Royal Infirmary
Foresterhill
Aberdeen
AB25 2ZN

Direct Line xxxxx

NHS Grampian

Hospital Trial ID Code:

OSCAR STUDY

WELFARE GUARDIAN/NEAREST RELATIVE CONSENT FORM

Version 1 – 12 June 2007
MainREC number: 07/MRE00/73

Regarding patient: ____
(please write patients name here)

Title of project: OSCAR: A study to investigate whether high frequency oscillatory ventilation or conventional positive pressure ventilation is of benefit to patients in the Intensive Care Unit.

1 I confirm that I have read and understand the information leaflet dated Version 1 – 12 June 07 for the above study and have had the opportunity to ask questions.

2 I understand that I am voluntarily agreeing to the above named patient's participation in the study and that I (or at a later date they), will be free to withdraw at any time, without giving any reason and without their medical care or legal rights being affected.

3 I confirm that I am acting as Welfare Guardian/Nearest relative for the above named patient who is currently incapacitated, and give my consent for them to join the OSCAR study and agree to the following:

- That the study office can contact the above named patient by post to find out how they are in six months time, or, if necessary they can contact the family doctor, or the friends/relatives named below for this.
- That sections of their medical record can be looked at by responsible individuals involved with the study and transcribed onto the study form.
- That appropriate personal identifying information will be collected, stored and used by the study office to enable follow up of health status. This is on the understanding that any information will be treated with the strictest security and confidentiality.
- That the Office of National Statistics can be used to aid follow up of their health (and that for this purpose their details may be sent, in confidence, to the study office).
- That their family doctor records may be looked at by their general practitioner to identify their location or health status in the future. These details may be shared with, and held at, the study office.
- That this consent form will be stored at the study office for monitoring purposes.
- That Members of the University of Oxford or Health Technology Assessment monitoring/auditing team may require access to my relatives details. Confidentiality of personal details will be maintained throughout this process.

If you would like further information before signing this form please contact:
[Name and telephone number here]

Continue over/,,,

4 I confirm I am the patients (tick one box): Welfare guardian ☐ Nearest relative ☐

If you answered 'nearest relative' above, please indicate:

(a) Your degree of kinship to the participant: ____________________

(b) I confirm there is no nearer relative (tick box): ☐

(c) I confirm there is no welfare guardian (tick box): ☐

Name (PRINT)	Date	Signature
Name of person taking consent	Date	Signature

Please provide contact details of 2 friends/relatives who can be written to for contact details if we lose contact with the patient named above (please PRINT)

Friend/relative 1

Name: ____________________

Address: ____________________

____

____________________ Post code: __________

Telephone (if known): __________ ____________________
(code)

Friend/relative 2

Name: ____________________

Address: ____________________

____

____________________ Post code: __________

Telephone (if known): __________ ____________________
(code)

Top copy: Study file at site 1 copy: Welfare guardian/nearest relative 1 copy: Patients hospital notes 1 copy: Post to study office