



Centre Number:

Study Number:

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Snapshot Obstetric National Anaesthetic Research project SONAR 1

Name of Researcher:

Please
INITIAL
boxes

☐

1. I confirm that I have read the information sheet dated.....[TBC]..... (version.....[TBC].....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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2. 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.

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3. I understand that the relevant sections of my medical notes, and data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust. This will occur only where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

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4. I understand that the anonymised information collected about me may be used to support other research in the future by this research group. It is possible that the data may be shared with other researchers, but this would be in its anonymised form only.

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I agree to take part in the above study.

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When the study is complete, a summary of the results will be written. The summary will be published as a press release to the funder and the sponsor for their websites, which are available for you.

Also, if you would like, we can send you this summary of the results. If you are interested in receiving this summary of results, you can put your email address below. This is entirely optional.



The study team would like to better understand the experiences of those who have had pain during surgery. We plan to do this by a telephone interview with patients. If you are happy for this optional part, we will contact you by email. Your contact details will not leave the hospital, and giving this information is entirely optional.

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Name of Participant

Date

Signature

Name of Person *taking consent*

Date

Signature