*(INSERT HOSPITAL/INSTITUTION LOGO HERE)*

Site Name: <<insert site name or site number>>

Patient study ID: <<insert patient study number>>

**CONSENT FORM: ADULT**

Name of Study: ICONIC**:** **I**mproving outcome through **C**ollaboration in **O**steosar**C**oma

**IRAS no.: 254908**

Name of Principal Investigator: <<insert name of Principal Investigator>>

**Please initial boxes**

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| 1. | I confirm that I have read and understand the information sheet dated 17 March 2023 (version 4) 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 and without my medical care or legal rights being affected. |  |  |  |
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| 3a. | I understand that relevant sections of my medical notes, and data collected during the study, may be viewed at the hospital/trial site or remotely by individuals from the study Sponsor, University College London and its representatives, including: CR UK and UCL Cancer Trials Centre (UCL CTC), my NHS Trust/Health Board and relevant regulatory authorities. |  |  |  |
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| 3b. | I understand that routine data may continue to be collected about me after my active participation in the study has finished and that I won’t need to attend any study visits for this.  |  |  |  |
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| 3c. | In addition, data collected may also be looked at by individuals at central laboratories that are processing, analysing and storing samples for this study. I understand that, for such sharing, UCL CTC would ensure that personal data items that could allow researchers to identify me directly are removed and a code used to link the information instead. |  |  |  |
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|  | I give permission for these individuals to have access to my data. |  |  |  |
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| 4. | I agree to my GP being informed of my participation in the study and providing information about me (relevant to my participation in the study) to the hospital research team. |  |  |  |
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| 5. | I understand that the information collected about me may be used to support other ethically approved research in the future, and may be shared with other researchers in the UK or abroad, in which case items that could directly identify me would be removed and a code used to link information. |  |  |  |
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| 6. | I agree to give tumour tissue samples from my surgery and/or biopsy, together with Germline DNA and CTC blood samples (where applicable) taken throughout my treatment and at follow up, for use in research related to this study. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand I will not benefit financially from this.If research blood samples cannot be taken at the same time as routine bloods please indicate your preference below:**Please tick Yes if you agree to samples still being taken:** Yes**Please tick No if you do not agree to samples still being taken:** No |  |  |  |
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| 7a. | This is optional. Please tick yes/no as appropriate and initial the box on the right.I agree to donating optional ctDNA blood samples for use in research related to this study. I understand that giving my samples is voluntary and that I am free to withdraw my approval for their use at any time without giving any reason and without my medical treatment or legal rights being affected. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand I will not benefit financially from this.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 7b. | ***[UCLH to include the following blue text and renumber subsequent row accordingly. All other sites to delete]******Chemotherapy patients only:******This is optional. Please tick yes/no as appropriate and initial the box on the right.***I agree to donating additional optional PBMC blood samples for use in research related to this study. I understand that giving my samples is voluntary and that I am free to withdraw my approval for their use at any time without giving any reason and without my medical treatment or legal rights being affected. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand I will not benefit financially from this.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 7b/c. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right.***I agree that my research samples and optional blood samples can be stored for use in future ethically and scientifically approved research in the UK or abroad, including genetic studies. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand I will not benefit financially from this.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 8. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right.***I consent to a biopsy of my cancer if the cancer comes back or spreads after treatment. I have had sufficient information and chance to discuss having a biopsy related to this research, and have had the risks explained to me.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 9. | I agree to genetic analyses of my blood and tissue samples. |  |  |  |
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| 10a. | I understand that results of genetic tests may include chance findings about my health, or the health of my blood relatives. |  |  |  |
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|  | I understand that I will be told about any results that could affect my **treatment**. |  |  |  |
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| 10b. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right***I would like to be told about chance findings about my **health**.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 10c. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right***I would like to be told about chance findings that may affect the health of my blood relatives.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| **11.** | **I agree to take part in the above study.**  |  |  |  |
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| Name of Patient: |  | Date: |  | Signature: |
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| Name of person taking consent (designated responsible person): |  | Date: |  | Signature: |
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***Instructions to site: when completed take 2 copies.***

***Original and 1 copy to be kept in medical notes and investigator site file,***

***and a copy to be given to the patient.***