*(INSERT HOSPITAL/INSTITUTION LOGO HERE)*

Site Name: <<insert site name>>

Patient Name: <<insert patient name>>

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

# CONSULTEE DECLARATION FORM

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 Consultee information sheet dated 17 March 2023 (version 3) for the above study. I have been consulted about my relative/friend’s participation in this research project. I have had the opportunity to consider the information and ask questions. I have had these answered satisfactorily. |  |  |  |
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| 2. | I understand that I can request he/she is withdrawn from the study at any time, without giving any reason and without their medical care or legal rights being affected. |  |  |  |
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| 3a. | I understand that relevant sections of his/her medical notes, and data collected during the study, may be looked at by individuals from the study Sponsor, University College London and its representatives, including: CR UK and UCL Cancer Trials Centre (UCL CTC), their NHS Trust or Health Board and relevant regulatory authorities.  |  |  |  |
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| 3b. | I understand that routine data may continue to be collected about my relative/friend after his/her active participation in the study has finished and that he/she 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 my relative/friend 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 relative/ friend’s data. |  |  |  |
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| 4. | I agree to his/her GP being informed of his/her participation in the study including any necessary exchange of information about him/her between my GP and the hospital research team.  |  |  |  |
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| 5. | I understand that the information collected about him/her 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 my relative/friend would be removed and a code used to link information. |  |  |  |
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| 6a. | I agree that my relative/friend can give tumour tissue samples from their initial surgery and/or diagnostic/resection biopsy, together with Germline DNA and CTC blood samples taken throughout his/her treatment and at follow up, for use in research related to this study. I understand that if these blood samples cannot be taken at the same time as routine bloods, they will not be collected. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand he/she will not benefit financially from this. |  |  |  |
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| 7a. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right.***I agree to the giving of my relative/friend’s optional ctDNA blood samples for use in research related to this study. I understand that giving his/her samples is voluntary and that if I decide that he/she would not wish to give approval for their use at any time I would withdraw approval without giving any reason and without his/her 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 he/she 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 my relative/friend donating additional optional PBMC blood samples for use in research related to this study. I understand that giving his/her samples is voluntary and that if I decide that he/she would not wish to give approval for their use at any time I would withdraw approval without giving any reason and without his/her 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 he/she 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 relative/friend’s 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 he/she 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. | I agree to genetic analyses of my relative/friend’s blood and tissue samples. |  |  |  |
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| 9a. | I understand that results of genetic tests may include chance findings about my relative/friend’s health, or the health of his/her blood relatives. |  |  |  |
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|  | I understand that I will be told about any results that could affect his/her **treatment**. |  |  |  |
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| 9b. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right.***I and my relative/friend would like to be told about chance findings about my relative/friend’s **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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| 9c. | ***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 relative/friend’s 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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| 10. | **In my opinion my relative/friend would have no objection to taking part in the above study.** |  |  |  |
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| Name of Consultee: |  | Date: |  | Signature: |
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| Relationship to participant: |  |  |  |  |
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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’s Consultee***