Partial prostate Ablation versus Radical prosTatectomy

CONSENT FORM

Patient Identification Number for this study: ☐☐ ☐☐ ☐☐☐☐☐ **Please initial**

1. I confirm that I have read and understand the patient information sheet dated _ _ / _ _ / _ _ _ _ (Version ____) for the PART study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that the type of treatment I receive will be allocated using a randomisation process, and neither myself nor the staff involved in the study can influence this allocation. ☐

3. I understand that if at any point my medical condition changes or the disease progresses, it may be necessary to withdraw from the trial and treatment options reviewed. This will be discussed with me by clinicians and with my agreement. ☐

4. I understand that I may be asked questions relating to personal aspects such as about diet and lifestyle, but I am under no obligation to answer these if I choose not to do so. ☐

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

6. I understand that information held by the NHS and records maintained by the NHS Information Centre and the NHS Central Register may be used to provide information about my health status. ☐

7. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason and without my medical care or legal rights being affected ☐

8. I give permission for the researchers to contact me in the future regarding this trial or the possibility of further studies, but I understand that I am under no obligation to take part in these. ☐

9. I agree for my GP and other doctors to be informed of my participation in this study. ☐

10. I agree to take part in the above study.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Please retain original consent form in the site file, give a copy to the patient and return a copy to the PART Offices (e-mail: part@nds.ox.ac.uk or fax: 01865 572 398)