Name of Researcher: Professor S E Lamb

ID No: *Please add ID Label here*

CONSENT FORM

If you would like to take part in this research study, please read this consent form carefully and then, if you agree with each of the seven statements, please sign**,** date **and print your name in the space provided** at the bottom of the form.

Please return the top two copies of the form (white and yellow pages) using the freepost envelope provided, and keep the third copy (pink page) for your records.

Thank you.

I confirm that:

1. I have read and understood the Patient Information Leaflet (Version 5, dated 12/07/2012) and have had the opportunity to ask questions.
2. I understand my participation is voluntary and that I am free to withdraw at any time, without having to give a reason and without my medical care or legal rights being affected.
3. I agree for my contact details to be held at Warwick Clinical Trials Unit for the purpose of sending me questionnaires and other study related material.
4. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the research team, 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.
5. I agree to my GP being informed of my participation in the study.
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 help contact me and provide information about my health status.
7. I agree to take part in this research study.

Signature: _____ Print Name: _____

Date: _____