Participant Information and Consent Form – Clinical Case Report or Series

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| **DETAILS** | |
| **Title:** | [insert] |
| **Author/s:** | [insert] |
| **Contact person:** | [insert] |
| **Contact phone:** | [insert] |
| **Contact email:** | [insert] |

* I give my consent for the review of all my medical records that are relevant for the purposes of this report, which has been explained to me by [**insert name of clinician**].
* I give my consent for the use of photos / images of me in this clinical case report ***(Note to Authors: Please delete this clause if not applicable to your clinical case report)***
* I understand that my name will not be published and that every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed. For example, members of my family or the health care staff who have looked after me may recognise me from the details of this case.
* I am aware that the report may be published in a medical journal and/or presented at conferences.
* I understand that the information collected will be stored securely and will only be accessible to the named authors.
* I understand that I can withdraw my consent, but only before the information has been published / presented.
* I understand that my decision to participate is voluntary, and if I do not consent to participation, or wish to withdraw my consent, this will not otherwise affect my treatment at **[enter hospital and/or clinic name].**
* I understand that this Clinical Case Report will be assessed for ethical risks by a sub-committee of the Adventist HealthCare Limited (“AHCL”) Ethics Committee, and if I have any concerns, I am able to contact the AHCL Research Office at [research@sah.org.au](mailto:research@sah.org.au).

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| **Name of Participant** (please print) | |  | | |
| **Participant Signature:** |  | | **Date:** |  |

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| **Name of Author** (please print) | |  | | |
| **Signature:** |  | | **Date:** |  |

Note: All parties signing the consent section must date their own signature.