 

**ISARIC/WHO Severe Acute Respiratory Infection Biological Sampling Study**

**INFORMED CONSENT FORM FOR PATIENT**

**13th May 2013. Version 2.5.0**

* I have read (or it has been read to me) the information sheet for this study. I understand the information and have had the opportunity to ask questions for clarification.
* I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason and without my medical care or rights being affected.
* I understand that data will be collected from my medical records by study staff during the study and that this information may be looked at by authorized individuals from public health agencies. I agree that these individuals may have access to my research records.
* I agree that my samples may be sent elsewhere in the world to be analysed.
* I agree that DNA from my blood sample will be analysed to determine whether any genetic factors have made me susceptible to severe infection.  
  OR IF YOU DO NOT AGREE, CHECK HERE ❑
* I agree that my blood sample, including my DNA, may be used in additional research in the future, if necessary in different parts of the world, as long as appropriate ethical approval is in place.  
  OR IF YOU DO NOT AGREE, CHECK HERE ❑
* I agree to be contacted directly by the investigators with an invitation to participate in future research studies.  
  OR IF YOU DO NOT AGREE, CHECK HERE ❑

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

Person taking consent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**Witnessed Consent**

***If the consenting party cannot read the form:*** I have no interest or involvement in this research study and I attest that the information concerning this research was accurately read and explained to the patient in language they can understand, and that informed consent was freely given by the patient.

Witness name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_