Boston Children's Hospital

RESEARCH CONSENT FORM

DO NOT PLACE IN MEDICAL RECORD

Use Plate or Print:

MRN#:

DOB:

Subject's Name:

Gender:

Protocol Title: Psychophysics of Visual Recognition

Principal Investigator: Gabriel Kreiman

Why is this research study being conducted; What is its purpose?

We are interested in understanding the mechanisms of visual object recognition. For this purpose, in this research effort, we aim to present images on a computer monitor and ask you to recognize, categorize, identify or memorize some of those images. In this research study, you will be seeing images containing single objects (e.g. faces, houses, cars, etc.), multiple objects or scenes on a computer. You may also be asked to watch a short segment of a movie. In some cases, you may be asked to wear special goggles or look at images through special mirrors so that we can show different images to your right and left eyes. In some cases, the images may be difficult to recognize. You will be indicating what you see by using a computer mouse, joystick or keyboard. There will be two test sessions, each one lasting 30 minutes. Throughout these measurements, we hope to gain insight into the mechanisms used by the brain to recognize faces and objects.

Who is conducting this research study, and where is it being conducted?

The research is conducted at Children's Hospital by a team of researchers headed by Gabriel Kreiman. Some tasks may be requested to be completed in person or remotely via an online interface.

How are individuals selected for this research study? How many will participate?

Subjects older than 2 years old may participate in this research study. We hope to enroll up to 500 subjects in this study.

What do I have to do if I am in this research study?

The research study is very similar to playing computer games or watching movies. You/your child would be asked to watch pictures presented on a computer display, to read words, to watch parts of movies. You/your child may be further asked to identify specific objects or characters, indicate□□□whether he/she remembers the objects. The responses would be by pressing a button (e.g. a computer mouse). □

What are the risks of this research study? What could go wrong?

There is no risk incurred as a result of participating in this study. The level of risk is the same as the one in watching TV or playing computer games. If performing the tasks is uncomfortable, tiring or annoying in any way, the test will be stopped. You can pause and/or stop the test at any time if you feel any discomfort.

What are the benefits of this research study?

We are performing basic scientific research. There is no direct benefit to you/your child for participating in this study. We hope to understand how the brain processes visual images.

Are there costs associated with this research study? Will I receive any payments?

There are no costs to you associated with this research study. You/your child may be given a token of appreciation and/or monetary compensation to thank you for participating in this study. Children will be given a token of appreciation. Adults will be paid $15 for participating.

What will happen with the information obtained as part of this research study? What about confidentiality?

All records associated with you/your child's participation in this study will be kept confidential. Results will not be placed in any medical record. Data are stored without identifiers.

If I do not want to take part in this research study, what are the other choices?

Participation in this study is voluntary. You can choose not to participate in the study.

Your privacy rights

If you or your child do not want to participate in this study, you do not have to. If you do want to participate, however, you must sign this form.

If you do not sign this form, it will not affect your care or your child's care at Boston Children's Hospital now or in the future and there will be no penalty or loss of benefits. You/your child can withdraw from the study and end your permission for Boston Children's Hospital to use or share the protected information that was collected as part of the research; however you cannot get back information that was already shared with others. Once you remove your permission, no more private health information will be collected. If you wish to withdraw your health information will need to do so in writing.

You/your child may have the right to get some the information that was shared with others for research, treatment or payment. This information is available after the study analysis is done. To request the information, please contact the Hospital's Privacy Officer at 857-218-4680.

Contact Information

I understand that I may use the following contact information to reach the appropriate person/office to address any questions or concerns I may have about this study. I know:

I can call…	At	If I have questions or concerns about
Investigator: **Gabriel Kreiman**	Phone: **617-919-2530** Pager: 617-355-7243 **[Pager #]**	▪ General questions about the study ▪ Research-related injuries or emergencies ▪ Any research-related concerns or complaints
Study Contact: **Rachel Wherry**	Phone: **617-919-4752** Pager: **[Pager #]**	▪ General questions about the study ▪ Research-related injuries or emergencies ▪ Any research-related concerns or complaints
Office of Clinical Investigations	Phone: **617-355-7052**	▪ Rights of a research subject ▪ Use of protected health information. ▪ Compensation in event of research-related injury

- Any research-related concerns or complaints.
- If investigator/study contact cannot be reached.
- If I want to speak with someone other than the Investigator, Study Contact or research staff.

Documentation of Informed Consent and Authorization

- I have read this consent form and was given enough time to consider the decision to participate in this study.
- This research study has been satisfactorily explained to me, including possible risks and benefits.
- All my questions were satisfactorily answered.
- I understand that participation in this research study is voluntary and that I can withdraw at any time.
- I am signing this consent form prior to participation in any research activities.
- I give permission for my/my child's participation in this research study and for the use of associated protected health information as described above (HIPAA).

Parent/Legal Guardian Permission (if applicable)

If the child to be involved in this research study is a foster child *or a* ward of the state *please notify the researcher or their staff who is obtaining your consent.*

■ _____ _____ _____

Date (MM/DD/YEAR) Signature of **Parent #1** or **Legal Guardian** Relationship to child

Child Assent (if applicable)

■ _____ _____

Date (MM/DD/YEAR) Signature of **Child/Adolescent Subject**

■ If child/adolescent's assent is **not** obtained above, please indicate reason below (check one):

☐ Assent is documented on a separate IRB-approved assent form
☐ Child is too young
☐ Other reason (e.g. sedated), please specify: _____

Investigator or Associate's Statement & Signature

- I have fully explained the research study described above, including the possible risks and benefits, to all involved parties (subject/parents/legal guardian as applicable).
- I have answered and will answer all questions to the best of my ability.
- I will inform all involved parties of any changes (if applicable) to the research procedures or the risks and benefits during or after the course of the study.
- I have provided a copy of the consent form sign by the subject/ parent / guardian and a copy of the hospital's privacy notification (if requested)

■ _____ _____

Date (MM/DD/YEAR) Signature of **Investigator or Associate**

Witness Statement & Signature

A witness must be present for the entire consent process in the following situations (please check the appropriate box)

☐ The individual cannot read and this consent document was read to the subject or legal representative, **or**

☐ The individual has certain communication impairments that limit the subject's ability to clearly express consent **or**

☐ Situations where the IRB requests a witness be present: please specify _____

I confirm that the information in this consent form was accurately explained to the subject, parent or legally authorized representative, the individual appeared to understand the information and had the opportunity to ask questions, and that informed consent was given freely.

☐ _____ _____

Date (MM/DD/YEAR) Signature of **Witness**

Or

☐ The individual is not English speaking and, through an interpreter, a short form consent document was presented orally to the subject or legal representative and this consent document serves as the summary for such consent.

I confirm that the information in this consent form was presented orally to the subject, parent or legally authorized representative, in a language they could understand and the individual had the opportunity to ask questions.

☐ _____ _____

Date (MM/DD/YEAR) Signature of **Witness** and **Interpreter**