**REMAP-CAP**

**Patient Video Consent Form**

**For patients with capacity or now recovered capacity**

**Consent video**

We are inviting people who have been admitted to hospital with COVID-19, influenza, or other pneumonia to participate in our research study. We have generated a video which provides information on the study, the treatments we are using, and risks and benefits of taking part. Once you have watched the video and are happy to continue please review and sign this consent form. You will also be provided with a full information sheet and privacy notice. This information is also available on our website <https://www.icnarc.org/Our-Research/Studies/Remap-Cap/About>

**CONSENT FORM FOR PATIENTS ABLE TO GIVE CONSENT**

**(FOR PATIENTS WITH CAPACITY or now RECOVERED CAPACITY)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Study ID** |  | **Site #** |  |
| **Name of Principal Investigator**  (use CAPITALS) |  | | |

**Please initial each box if you agree with the following:**

I, *(forename and surname)*……………………………………………………………………………………………… freely agree to take part in the study.

|  |  |
| --- | --- |
|  | 1. I confirm that I watched the consent video for the above study and have been able to ask questions which have been answered fully. |
|  | 2. I agree/continue to take part in the following domains: - **anticoagulation domain, cysteamine domain, immunoglobulin domain, influenza antiviral domain, steroid domain, immune modulation domain, antibiotic domain,** or **macrolide domain** (d*elete domains not participating in and strikethrough domain if patient does not agree)* |
|  | 3. I understand that my participation is voluntary, and I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected. |
|  | 4. I understand my identity will never be disclosed to any third parties and any information collected will remain confidential. |
|  | 5. I agree that my medical records and other personal data generated during the study may be examined by representatives of the sponsor (UMC Utrecht), by people working on behalf of the sponsor, and by representatives of Regulatory authorities, ICNARC and NHS Digital where it is relevant to my taking part in this research. |
|  | 6. I agree that I will not seek to restrict the use to which the results of the study may be put. |
|  | 7. I understand I will be contacted by ICNARC or my local hospital in six months to ask about my quality of life and wellbeing. (*delete if not taking part in follow-up aspect)* |
|  | 8. I understand that minimal randomisation data collected about me will be transferred outside of the EEA.  *(Note if this point is refused the patient cannot be included in the trial)* |

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Name of patient Signature Date

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Name of staff member Signature Date

*(Listed on delegation log)*

*If the patient is* ***not able*** *to write/sign due to condition or weakness, please ensure a witness signs the section of the consent form below. The witness will be a member of the clinical team who is not part of the study team (not listed on the delegation log)*

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Name of witness Signature Date

*\*Independent of the REMAP-CAP study team*

1 copy for participant; 1 copy for Principal Investigator; 1 copy for hospital notes

To ensure confidence in the process and minimise risk of loss, all consent forms must be printed, presented, and stored in double sided format