PARTICIPANT INFORMATION LEAFLET

HOSPITAL:

DEPARTMENT:

STUDY TITLE:

NAME OF PRINCIPAL INVESTIGATORS:

Dr., Mr., Ms.

You are being invited to participate in a research study. Thank you for taking time to read this.

WHAT IS THE PURPOSE OF THE STUDY?

WHY HAVE I BEEN CHOSEN TO PARTAKE IN THIS STUDY?

WHAT WILL HAPPEN IF I VOLUNTEER TO PARTICIAPTE?

ARE THERE ANY RISKS INVOLVED IN PARTICIPATING?

ARE THERE ANY BENIFITS INVOLVED IN PARTICIPATING?

WHAT HAPPENS IF I DO NOT AGREE TO PARTICIPATE?

WILL MY PARTICIPATION OR WITHDRAWEL HAVE ANY IMPACT ON MY ROUTINE CARE?

WILL MY PARTICIPATION BE CONFIDENTIAL?

INDEMNITY

Your doctors are insured by the State Claims Insurance Service.

WHO IS ORGANISING AND FUNDING THIS RESEARCH?

HAS THIS STUDY REVIEWED BY AN ETHICS COMMITTEE?

Yes

CONTACT DETAILS

Name:

Address:

Phone: