## Participant Information Sheet and Consent Form for Case Report

**Metro North Health**

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| --- | --- |
| Title: |  |
| Practitioners Name: |  |
| Case Study Title: |  |
| Institution: |  |
| Contact number: |  |

You are being asked to consider allowing us to use information about your condition to write what is called a case report. Case reports are typically used to share new or unique information related to your condition or clinical care that may be useful for other physicians and members of a health care team.

A case report may be published (in print and/or via internet dissemination) for others to read, and/or presented at a conference. This form explains the purpose of this case report. Please read this form carefully and take your time to make your decision and ask any questions that you may have.

The purpose of this case report is to inform other physicians that **[insert details or specific reason i.e. patients presenting to the ER with X) may be related to Y, however, was masked by a common over the counter medication Z].**

Dr. (insert name) is obligated to protect your privacy and not disclose your personal information (information about you and your health that identifies you as an individual e.g. name, date of birth, medical record number). When the case report is published or presented, your identity will not be disclosed.

Although your personal information collected or obtained will be kept confidential and protected to the fullest extent of the law, there is a limited risk associated with this case report that could result in a loss of confidentiality by virtue of your unique experience.

You will not directly benefit from participating in this case report. However, the information that can be shared with other health care professionals may improve the care that is received by others in the future.

Allowing your information to be used in this case report will not involve any additional costs to you. You will also not receive any compensation.

Taking part in this case report is your choice (voluntary). You may choose not to take part, or you may change your mind at any time. However, once the case report is written and published, it will not be possible for you to withdraw your consent. Your decision will not result in any penalty or loss of benefits to which you are entitled including the quality of care you receive.

You will be told about any new information relating to this case report that may affect you.

Your signature below means that you have read the above information about this Case Report and have had a chance to ask questions to help you understand how your information will be used and that you give your permission for your information to be used in this case report.

If you would like further information about this project, please use the contact details at the top of the form.

## Case Study Report Participant Consent

|  |  |
| --- | --- |
| Title: |  |
| Practitioners Name: |  |
| Case Study Title: |  |
| Institution: |  |
| Contact number: |  |

I agree to take part in the case study specified above. I have had the case study explained to me, and I have read the Participant Information Sheet, which I will keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed by the researcher(s)  **Yes  No**

I allow the researcher(s) to access my clinical records for  **Yes  No**

the purpose of preparing and publishing a case study report

I allow the researcher(s) to prepare and publish the  **Yes  No**

aforementioned case study report

I understand that my participation is voluntary, that I can choose not to participate in part or all of the case study, and that I can withdraw at any stage of the case study without being penalised or disadvantaged in any way.

I understand that any data that is extracted from the interview or from my clinical records for use in a case study report will not, under any circumstances, contain my name or personal information about me which has not been de-identified.

I understand that because the case study report will describe a rare event, my confidentiality cannot be guaranteed and there remains a possibility that my identity may be guessed or discovered by someone reading the case study report. However, I understand that any information I provide is confidential, and that no information about me will be disclosed in any case study report, or to any other party, without first being de-identified.

I understand that the case study report based on the interview(s) and my clinical records will be kept in secure storage and will be accessible to authorised personnel. I also understand that any of my confidential information held will, in accordance with legal requirements, be kept for a period of five years before being destroyed.

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| Name of Case Study Participant/ Legally Authorised Representative: |  |
| Signature of Participant/Legally Authorised Representative: |  |
| Date: |  |
| Practitioners Name: |  |