Local PPiP2 researcher: *<add name and contact details*>

Principal Investigator: <*add name and contact details*>

**CONSENT FORM**

**WELFARE GUARDIAN /WELFARE ATTORNEY/NEAREST RELATIVE**

*Study title: Prevalence of Pathogenic Antibodies in Psychosis 2 (PPiP2)*

Participant Identification Number for this study:

|  |
| --- |
|  **Please initial boxes** |
|  | I confirm that I have read and understand the Participant Information Sheet (PIS)-Welfare Guardian/Welfare Attorney/Nearest Relative, Version no……..., date ……………….[ *put in the actual version number and date of**the PIS that is being submitted at the same time as this Consent Form*] for the above studyand have had theopportunity to consider the information and ask questions. |  |
|  | I understand that my ward/relative/ person I am consenting for’s participation is voluntary and that I am free to withdraw my ward/relative/person I am consenting for at any time, without giving any reason and without my ward’s/relative/person I am consenting for’s medical care or legal rights being affected. |  |
|  | I understand the researchers will discuss my ward/relative/ person I am consenting for’s case with his/her hospital/community doctor or GP, examine his/her medical records. I understand that all data will be kept confidential and secure. |  |
|  | I understand that my ward/relative/ person I am consenting for’s GP and hospital/community doctor will be informed about his/her participation in the study and any relevant clinical information.  |  |
|  | I understand that blood will be collected from my ward/relative/ person I am consenting for’s for the study. I understand that if their blood sample was recently taken by his/her clinical team to test for neuronal membrane antibodies it may be used for the study. I understand that these samples are considered as a gift to the University of Oxford and I understand he/she will not gain any direct personal or financial benefit from this. |  |
|  | I understand that relevant sections of my ward/relative/ person I am consenting for’s medical notes and data collected during the study may be looked at by authorized individuals from the University of Oxford, from regulatory authorities, NHS Organisation(s) where it is relevant to his/her taking part in this research. I understand these individuals will have access to my ward/relative/person I am consenting for’s records. I give permission for these individuals to have access to their records. |  |
|  | I agree to my ward/relative/person I am consenting for taking part in the above study. |  |
| Optional |
|  | I understand that his/her anonymised samples will be indefinitely stored and used in future research studies, here or abroad, which have ethics approval. I understand this research may involve commercial organisations. I agree to my ward’s/relative/person I am consenting for’s anonymised tissue being used in future studies.  *Or if you think that the participant would not want this tick here instead* ❑ |   |
|  | I understand that his/her de-identified samples may be used in future genetic research studies, here or abroad, which have ethics approval. They are aimed at understanding the genetic influences on disease and the results of these investigations are unlikely to have any implication for him/her personally. I understand this research may involve commercial organisations. I agree to my ward/relative/person I am consenting for giving samples which will be used for genetic (DNA) analysis.*Or if you think that the participant would not want this tick here instead* ❑ |  |
|  | I understand that he/she may be contacted about SINAPPS2 study or other relevant ethically approved research studies, for which they may be suitable. I understand that they are not obliged to participate in any further studies.  *Or if you think that the participant would not want this tick here instead* ❑ |  |
| I confirm that I am the Welfare Guardian or Welfare Attorney or the Nearest Relative for: |  |
| Relationship with the participant e.g. wife, husband, brother/ welfare guardian, welfare attorney: |  |
|  |  |  |
| *Name of person giving WG/WA/NR’s consent* | *Date: dd/mmm/yyyy* | *Signature* |
|  |  |  |
| *Name of person taking consent* | *Date dd/mmm/yyyy* | *Signature* |

***1x original – into medical records; 1x copy – to WG/WA/NR; 1x copy – into Site File***