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

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

*Participant study ID:*

**CONSULTEE VERBAL DECLARATION FORM**

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

**Name of Participant***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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| --- | --- | --- | --- | --- |
| **Researcher to seek and record informed verbal consent, after consultee has had sufficient time to think about whether they want to take part.**  Please check (√) the boxes to record that the statement has been asked by the researcher and that the consultee has responded in the affirmative way: | | | | |
|  | Do you confirm that you have read the information sheet for consultees dated……… (version…..) for this study? Have you had the opportunity to consider the information, ask questions and have these answered satisfactory? | | |  |
|  | Do you understand that participation in the study is voluntary and that you or your relative/friend/patient ( if they regain capacity) can withdraw at any time, without giving any reason and without his/her medical care or legal rights being affected. | | |  |
|  | Do you understand that researchers will discuss his/her case with his/her hospital/community doctor or GP and examine his/her their medical records, and that all data will be kept confidential and secure? | | |  |
|  | Do you understand that his/her GP and hospital/community doctor will be informed of his/her participation in the study and any relevant clinical information. | | |  |
|  | Do you understand that blood will be collected from him/her for the study or if his/her blood sample was recently taken by his/her clinical team to test for neuronal membrane antibodies – do you understand that it may be used for the study? Do you understand that these blood samples will be considered as a gift to the University of Oxford? Do you understand that his/her will not gain any direct person or financial benefit from this? | | |  |
|  | Do you understand that relevant sections of his/her medical records and data may be looked at by the authorised members of the research team, University of Oxford, from regulatory authorities, and from the NHS Organisation(s), where it is relevant to his/her taking part in this research. | | |  |
|  | Do you confirm that, in your opinion, he/she would have no objection to taking part in the above study? | | |  |
| Optional | | | | |
|  | Do you understand that his/her anonymised samples will be indefinitely stored and used in future research studies, here or abroad, which have ethics approval? Do you understand this research may involve commercial organisations? *Or do you think that the participant would not want this? Tick if declined* ❑ | | |  |
|  | Do you 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? Do you understand this research may involve commercial organisations?  *Or do you think that the participant would not want this? Tick if declined*❑ | | |  |
|  | Do you understand that he/she may be contacted about SINAPPS2 study or other relevant ethically approved research studies, for which they may be suitable? Do you understand that they are not obliged to participate in any further studies?  *Or do you think that the participant would not want this? Tick if declined* ❑ | | |  |
|  | |  | | |
| *Name of consultee* | | *Relationship with the participant e.g wife, brother/ nominated professional consultee* | | |
|  | |  |  | |
| *Name of person taking Consultee’s Verbal Declaration* | | *Date(dd/mmm/yyyy)* | *Signature* | |

*\*Original into medical record, 1x copy to site file; 1x copy to consultee (if emailing please send as a password protected attachment using @nhs.net)*