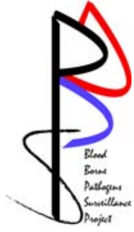


RECONSENT FORMS

Please use these forms (Adult and Child) after the first year to re-consent your patients.

**Note – persons may only re-consent if he/she has already consented one year prior.

Adult Re-Consent

Please Print

Patient CHR Number ______________________________ Date ___________

This form is voluntary.

Do you agree to re-consent in the Blood Borne Pathogens Surveillance Study? Yes No

If no, please complete patient withdrawal form. Thank you.

To be completed by the research subject:

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records?	Yes	No
Do you want the investigator(s) to inform your family doctor that you are participating in this research study? If so, please provide your doctor's name:	Yes	No

____

This study was explained to me by: ______________________________

I agree to take part in this study.

_____________________________ ________________ ______________________________

Signature of Research Participant Date Witness

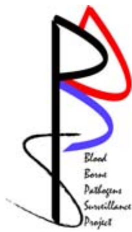
_____________________________ ______________________________

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_________________________________ _________________

Signature of Investigator or Designee Date



Child Re-Consent

Please Print

Patient CHR Number ______________________________ Date __________

This form is voluntary.

Do you and your child agree to re-consent in the Blood Borne Pathogens Surveillance Study?

Yes No

If no, please complete patient withdrawal form. Thank You.

To be completed by the parent/legal guardian:

Do you understand that your child has been asked to be in a research study? Yes No

Have you and your child read and received a copy of the attached Information Sheet? Yes No

Do you understand the benefits and risks for your child in taking part in this research study? Yes No

Have you and your child had an opportunity to ask questions and discuss this study? Yes No

Do you and your child understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect his/her care. Yes No

Has the issue of confidentiality been explained to you and your child? Do you understand who will have access to your child's records? Yes No

Do you want the investigator(s) to inform your family doctor that your child is participating in this research study? If so, please provide your doctor's name: ______________________________ . Yes No

This study was explained to me by: ______________________________

____
Signature of Child

I consent for my child to take part in this study.

______________________________ ________________ ______________________________
Signature of Parent/Legal Guardian Date Witness

______________________________ ______________________________
Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily consents to have his/her child participate.

______________________________ ________________
Signature of Investigator or Designee Date