**SOLVe TRIAL**

**Sampling of the Lateral Ventricle**

**Understanding the impact of Intraventricular Haemorrhage on Brain Development in the Premature Neonate**

**Parent / Guardian Consent Form**

**Version 1.0**

**21st May 2018**

**Patient’s initials: \_\_\_\_\_ Hospital number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_**

|  |  |
| --- | --- |
|  | **Please initial box** |
| 1. **I confirm that I have read and understand the information sheet dated 21/05/18 Version 1.0 for the above study. I have had the opportunity to consider the information, ask questions, and have these answered satisfactorily.** |  |
| 1. **I understand that participation is voluntary and that I am free to withdraw my child at any time, without giving a reason, and without my child’s care or legal rights being affected.** |  |
| 1. **I understand that my child's medical data will be collected for this study and may be used in this and in future research** |  |
| 1. **I understand that relevant sections of any of my child's medical notes and data collected during the study may be looked at by responsible individuals from the research team, regulatory authorities, sponsor or from the NHS Trust, where it is relevant to my child taking part in this study. I give permission for these individuals to have access to my child's records** |  |
| 1. **I agree to my child gifting a sample of up to a maximum of 10mls of additional CSF and 2mls of blood for storage at Great Ormond Street Hospital or the Institute of Child Health and used in research.** |  |
| 1. **I agree to my child gifting a sample of tissue from the wall of the lateral ventricle for use in research** |  |
| 1. **I agree to take part in the above study.** |  |
| 1. **Optional : I agree that I may be contacted in the future in relation to this study.** | **Yes**  **No** |

Name of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Name of Clinician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Clinician: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_