DIVISION OF CARDIOVASCULAR MEDICINE,

RADCLIFFE DEPARTMENT OF MEDICINE

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Study Code: *Participant identification number:*

P	O					

Physician Optimised Post-partum Hypertensive Treatment (POP-HT) Study

CONSENT FORM

Name of Researcher: *[insert name of consenting study staff]*

Participant Name: *[insert name of participant]*

If you agree, please initial each box

1. I confirm that I have read the information sheet dated V2.0 17/12/19 for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3. I understand that relevant sections of my medical records and data collected during the study may be looked at by individuals from University of Oxford, hosting NHS organisations and regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4. MRI/Echocardiography/other research tests: I understand that these are research scans/tests that are not useful for medical diagnosis, and that scan/test results are not routinely looked at by a doctor. If a concern is raised about a possible abnormality on my scan/research test, I will only be informed if a doctor thinks it is medically important such that the finding has clear implications for my current or future health.	
5. I agree for my GP to be informed of any results of medical tests performed as part of the research that may be important for my health care.	
6. If I withdraw/I am withdrawn from the study we will contact your GP to inform them, in order to ensure that any on-going care you require is reinstated.	
7. I agree that the information held and maintained by NHS Digital/ Office for National Statistics (ONS) may be used to provide information about my health status. I understand that my name, NHS number, date of birth and postcode may be shared securely to obtain such information and allow contact for blood pressure, and other relevant measurements over the next 10 years.	

8. I agree to donate blood samples. I consider these samples a gift to the University of Oxford and I understand I will not gain any direct personal or financial benefit from them.		
9. I understand that retinal images will be taken as part of the study and will be stored in a de-identified format on the high compliance (secure) server of the University of Oxford for up to 10 years		
10. I agree to take part in this study		
Additional:	Yes	No
11. I agree for my anonymised samples to be used in future research, here or abroad, which has ethics approval. I understand this research may involve commercial organisations.		
12. I agree to be contacted about ethically approved research studies for which I may be suitable. I understand that agreeing to be contacted does not oblige me to participate in any further studies.		
13. I have been approached about the optional additional measure: Laser Speckle Tracking of the skin on my fore-arm and agree to partake in this additional measure (being done in 48 participants out of 200)		

Name of Participant	*Date*	*Signature*
Name of Person taking Consent	*Date*	*Signature*

**** For researchers please tick (✓) to document:***

The original signed form will be placed in the medical notes and a further copy will be retained at the trial site and one given to the participant ( )