Informed Consent Form

Nasal Intubation Using King Vision Video Laryngoscopy

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(NCT03126344)

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Introduction

We sincerely invite you to participate in this clinical trial: “Nasal Intubation Using King Vision Video Laryngoscopy” The purpose of this study is to understand the effect of King Vision video laryngoscope in nasotracheal intubation, and to compare the effect of King Vision video laryngoscope and McGrath MAC video laryngoscope, so as to provide some basis for the application and development of King Vision video laryngoscope in nasotracheal intubation. Before you decide to participate, it is necessary to understand the purpose and content of the study. Please read this introduction carefully and discuss it with your doctor, family and friends. If there is anything unclear, or if you want to know more, please ask your doctor or contact the person listed after the introduction directly.

What is the purpose of the study?

In order to understand the effect of King Vision video laryngoscope in nasotracheal intubation and compare the effect of King Vision video laryngoscope and McGrath MAC video laryngoscope, we observed the intubation time of nasotracheal intubation, the influence of hemodynamics and complications after nasotracheal intubation with King Vision video laryngoscope, McGrath MAC video laryngoscope and Macintosh video laryngoscope in patients with suspected difficult airway. Thus, it provides a certain basis for the application and development of King Vision video laryngoscope in nasotracheal intubation.

Why were you chosen?

Because your conditions are in accordance with the inclusion criteria.

Is the study dangerous??

No.

Do you need to spend or get paid?

This research will not bring you any expenses. We have no reward to thank you.

Is my information confidential?

In the course of the study, all information about you is strictly confidential. Only relevant personnel can check your medical records so that they can check the accuracy of the information collected and ensure that the research is carried out properly. Any information transmitted electronically will be renamed to ensure the confidentiality of the information. All information on the computer will be protected with a password. The results of the study may be reported at medical conferences and published in scientific journals. However, any information that can identify you will not be used.

Do I have to attend?

Participation in the study was voluntary rather than forced. If you participate in the study, you can drop out at any time without any reason. No matter what your decision is, it will not affect your normal treatment or your relationship with the health care staff. If you decide to participate, we will ask you to sign an informed consent form. You will keep a copy of the consent form and this introduction.

Who did the research?

This study was carried out and cooperated by the Department of Anesthesiology, Shanghai Ninth people's Hospital.

Who should I contact if I need more information?

After reading the introduction and discussing with your doctor, if you have any other questions or concerns, please contact the following personnel: researcher: Yu Sun

Tel: 021-23271699

Address: anesthesiology Department of Shanghai Ninth people's Hospital

Who approved the study?

This study has been approved by the Medical Ethics Committee of the Ninth people's Hospital affiliated to the Medical College of Shanghai Jiaotong University. Anyone who has questions or complaints about this study can contact the Medical Ethics Committee directly: 23271699-5576.

Study on the signature page of the subject's informed consent form

The doctor has explained to me in detail the purpose and process of the trial, as well as the possible risks and benefits of taking the trial drug. I have carefully read the instructions for the subjects and have time to ask questions. I do not have any questions at present.

I participate in this experiment voluntarily. I can withdraw from the experiment at any time for any reason and will not suffer any loss. In the course of the experiment, I will follow the guidance of the research doctor. If any adverse events occur during the trial, I will immediately notify the clinical trial physician or other researchers. If this trial causes any obvious damage to my health (as mentioned in the trial scheme and instructions), I will be compensated by the active treatment and sponsor (XX Co., Ltd.).

I know that if I use other drugs myself without prior discussion with the research doctor, and if there is any problem with my health, if I do not inform my research doctor in time, it will affect my protection in the trial.

I agree that the data obtained from this clinical trial can be recorded, stored and processed in a computer. In addition, I agree that representatives of the sponsors, members of the Ethics Committee and representatives of government management should consult my case records in accordance with the principle of confidentiality. I understand that the purpose of checking these records is to ensure that the information collected from this experiment is true, accurate and reliable.

To sum up, I agree to participate in this clinical trial, and I have obtained a copy of this signed informed consent form. Subject name (print) subject signature date implementation informed consent researcher name (print) researcher signature date

Subject name（block letter）	Signature	Date
_____	_____	_____