

## SAMPLE CONSENT FORM



**St Patrick's**  
Mental Health Services

### CONSENT FORM

**The participant must complete this form herself/himself**

Title of Project \_\_\_\_\_

Protocol Number: \_\_\_\_\_ Patient ID Number: \_\_\_\_\_

### PLEASE TICK YOUR RESPONSE

I have read and understood the attached Participant information leaflet	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have had the opportunity to ask questions and discuss the study	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have received satisfactory answers to all my questions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I understand that I am free to withdraw from the study at any time without giving a reason and without this affecting my future medical care	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I agree to take part in this study without prejudice to my legal or ethical rights	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant's Name in Print: \_\_\_\_\_

Witness Signature:\* \_\_\_\_\_ Date: \_\_\_\_\_

Witness' Name in Print: \_\_\_\_\_

Investigator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Investigator's Name in Print: \_\_\_\_\_

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**If the participant is under 18 years of age the consent of the parent or guardian must also be obtained.**

I have received, read and understood the Patient Information Leaflet for the above study. The participant named above expressed a written willingness to participate in this research study and I hereby give my consent for this participation:

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name in Print: \_\_\_\_\_

**Please attach the Participant Information Sheet to this Consent Form, ask the participant to sign and date it and, where appropriate, place a copy of both in the participant's case notes.**

\*Witness must be somebody other than the Investigator