**Biomarker for Monitoring Ovarian Reserve Study**

**Control Consent form (2 years and over)**

***This means you can say no***

|  |  |  |
| --- | --- | --- |
| *Affix Hospital Centre**Logo here* | Patient Name: | Medical Record Number: |
| □ Male □ Female |
| M.O |
| Given Name: |
| Address: |
| Location/ward: |
| A new biomarker to measure ovarian quantity and ovarian quality study |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree for myself/my child to participate in the biomarker for measuring ovarian quantity and ovarian quality as described in the control patient information sheet provided (version 3.1, 27th of May 2016).

* I have read the patient information sheet myself/ behalf of my child or have had it read to me in my first language, and I understand it.
* I have been given the opportunity to ask any questions on behalf of myself/my child and I have received satisfactory answers.
* I understand that I can withdraw my/my child’s consent at any time without giving a reason and know that this will not affect any medical treatment received by myself/ my child now or in the future.
* I understand and agree that research data gathered from my/my child’s participation in the study will be published but my child will not be identified.
* I understand that if I have any questions relating to my/ my child’s participation that I can contact the study coordinator directly using the contact details provided in the patient information sheet.
* I acknowledge receipt of a copy of the patient information sheet for my/my child’s records.

**Please read carefully and tick either YES or NO**

1. I give my permission for my/my child to have their personal data entered onto the study database

 □Yes □No

1. I give permission for my/my child’s notes to be reviewed by the research team.

 □Yes □No

**DECLARATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_/\_\_\_\_

CHILD PRINT NAME SIGNATURE Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_/\_\_\_\_ PARENT/GUARDIAN PRINT NAME SIGNATURE Date

(this will need to be signed if the child is less than 18 years of age)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_/\_\_\_\_ WITNESS PRINT NAME SIGNATURE Date

WITNESS

This study has been approved by the South Eastern Sydney Local Health District Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the Research Support Office, which is nominated to receive complaints from research participants. You should contact them on 02 9382 3587, or email RSOseslhd@sesiahs.health.nsw.gov.au and quote 15/298.

The conduct of this study at the [*NAME OF SITE*] has been authorised by the [*NAME OF HEALTH DISTRICT*]. Any person with concerns or complaints about the conduct of this study may also contact the [*DETAILS OF THE RESEARCH GOVERNANCE OFFICER OF THE HEALTH DISTRICT*].

**We would be grateful if you could please print this form double-sided**