

Mother's Consent Form

Thank you for reading the information about this study. If you would like to take part, please read and sign this form. Please initial each box if you agree with the accompanying statement:

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| 1. I have read the study information leaflet and have been given a copy to keep. I have been able to ask questions about the study and I understand why the research is being done. | <input type="checkbox"/> |
| 2. I understand that my and my baby's participation in this study is entirely voluntary and that I will not receive any payment. I am free to withdraw my consent at any time without giving a reason and without my or my baby's medical treatment being affected. | <input type="checkbox"/> |
| 3. I give my permission for a member of the research team to access, examine and record information from my maternity and hospital records. | <input type="checkbox"/> |
| 4. I give my permission for a member of the research team to access, examine and record information from my baby's neonatal and hospital records. | <input type="checkbox"/> |
| 5. I give my permission for a member of the research team to access, examine and record information from my general practitioner (GP) records. | <input type="checkbox"/> |
| 6. I give my permission for a member of the research team to access, examine and record information from my baby's general practitioner (GP) records. | <input type="checkbox"/> |
| 7. I agree to a cord blood sample being taken at the time of my baby's birth. I agree to this sample being stored and used for future research projects. (You and your baby may still take part in the study even if you do not wish to give permission for a cord blood sample.) | <input type="checkbox"/> |
| 8. I give my permission for the DNA / RNA extracted from my cord blood sample to be stored and retained for use in any future research projects. | <input type="checkbox"/> |
| 9. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give my permission for these individuals to have access to my records. | <input type="checkbox"/> |
| 10. I understand that all information about me and my baby will be treated confidentially and that the results from any tests will not be used or released in such a way that we could be identified. | <input type="checkbox"/> |
| 11. I understand that any research project will be approved by the relevant ethics committee and that my child's consent will be sought for any future research and tests if they are old enough to give informed consent at that time. | <input type="checkbox"/> |
| 12. I agree to my family doctor (GP) being informed that I am taking part in this study. | <input type="checkbox"/> |
| 13. I agree to be contacted again. | <input type="checkbox"/> |

Mother's surname: _____ Mother's first name: _____

Signature: _____ Date: _____

PLEASE RETURN THE TOP FOUR COPIES OF THIS FORM IN THE ENVELOPE PROVIDED. THE YELLOW COPY IS FOR YOU TO KEEP.