**Do you consent to take part in the study?**

**ISCOMAT: Improving the safety and continuity of medicines management at care transitions**

**Please read each of the following points and tick the box if you agree. Just ask**

**If there is anything you don’t understand or you are unsure about.**

1. I confirm that I have had the opportunity to ask questions about the study

and, if I asked, my questions were answered fully.

1. I have read and understand the information sheet version [….] date [………….]
2. I understand that my participation is voluntary and I am free to withdraw at any

time without giving any reason, and without my medical care being affected.

1. I understand that the hospital will send a copy of my discharge advice note / letter – including information about the reason for my admission, my treatment in hospital and a list of my discharge medicines – to my regular community pharmacy (or one that I choose) and that the hospital will ask the community pharmacist to contact me to offer me a medicines review.
2. I understand that the University will contact my community pharmacy to ask if

they have received my medicines list, ask if I have been invited for a medicines review and if I attended a medicines review.

1. I agree to allow any information or results arising from this study to be used for healthcare and/or further medical research upon the understanding that my identity will remain anonymous.
2. I understand that all data collected about me will be kept confidentially and securely.
3. I understand that the interview I take part in will be audio recorded and that anonymous quotes may be used in reports and publications about the research
4. I understand that the research team will inform my GP and my community pharmacy that I am taking part and send them copies of this completed consent form
5. I agree to take part in the above study……………………………......................

**Your name (print)…………………………………..........................................................**

**Your signature …………………………………................... Date ……………...**

**Research nurse signature ……………………………….. Date ……………..**

**About you**

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NHS number: ­­­­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender:** 🞎 Male 🞎 Female

Your contact details:

**Home address:**

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**Postcode:** ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact email address (if you have one):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile number (if you have one):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GP name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GP surgery:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which community pharmacy do you usually use for you prescriptions (Pharmacy name and location)?**

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**If you do not have a usual community pharmacist, please tell us which pharmacy you have chosen to dispense your prescriptions after you leave hospital.**

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*[Patient ID number [for office use only]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]*

**Thank you**