### welfare attorney/Welfare Guardian or Nearest relative consent form FOR DECEASED PATIENT

Version: 5, 23 October 2024

Local Lead Investigator: [local\_lead\_investigator\_name]

Chief Investigator: Prof JK Baillie, University of Edinburgh

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| * I have read the information sheet (v5 – 23 October 2024) for this study (or it has been read to me). I understand it and have had the opportunity to ask questions. * I agree for a DNA sample to be taken and for this sample to be analysed to look for genetic factors important in critical illness. * I can withdraw the deceased patient from the study at any time without giving any reason. * The deceased patient’s DNA, and data derived from their DNA, including the whole sequence of their genome, may be stored and used for future research. Researchers may include national or international scientists, companies and NHS staff. To access the data, researchers must all be approved by an independent committee of experts, including clinicians, scientists and patients. There will be no access to the data by personal insurers or marketing companies. * Different aspects of the deceased patient’s health data will be collected by the GenOMICC investigators, the study sponsor (NHS Lothian and the University of Edinburgh), and partner organisations. |
| I can confirm I am the nearest relative, welfare guardian or welfare attorney for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and that no other nearest relative welfare guardian or welfare attorney exists.  Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please sign here to indicate that you agree with the statements above:**

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print name of person taking consent  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of person taking consent  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print name of welfare attorney/guardian or nearest relative  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of welfare attorney/guardian or nearest relative  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***If the person giving consent cannot write or read the form:***  I have no involvement in this research study and I attest that the information concerning this research was accurately explained to the participant in language they can understand, and that informed consent was given freely by the nearest relative/welfare attorney. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print name of witness  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of witness  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Original to be retained in site file. One copy to be given to the patient’s welfare attorney/guardian or relative.