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| Consent Form**(A study to assess the acceptability of a pharmacist-led intervention on polypharmacy in older adults)**Formal Research Title:Feasibility and acceptability of a novel pharmacist-led intervention to manage inappropriate polypharmacy in older adults presenting to general practice. | Level 3, Building 50585, Park Road,Auckland 1023New Zealand**T:** +64 9 9232144**W:** [fmhs.auckland.ac.nz](http://www.fmhs.auckland.ac.nz)\sop**The University of Auckland** Private Bag 92019Auckland 1142New Zealand |

*An interpreter is available on request if required.*

**Please tick to indicate you consent to the following**

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| I have read, or have had read to me in my first language, and I understand the Participant Information Sheet.  |  |  |
| I have been given sufficient time to consider whether or not to participate in this study. |  |  |
| I have had the opportunity to use a legal representative, whanau/ family support or a friend to help me ask questions and understand the study. |  |  |
| I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and participant information sheet. |  |  |
| I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without this affecting my medical care. |  |  |
| I consent to the research staff collecting and processing my information, including information about my health. |  |  |
| I consent for research staff to share any irregular findings of potential significance to my health to my GP/NP. |  |  |
| If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed. | Yes 🞏 | No 🞏 |
| I consent to my GP/NP or current provider being informed about my participation in the study and of any significant abnormal results obtained during the study. | Yes 🞏 | No 🞏 |
| I agree to an approved auditor appointed by the New Zealand Health and Disability Ethics Committees, or any relevant regulatory authority or their approved representative reviewing my relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study. |  |  |
| I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study. |  |  |
| I understand the compensation provisions in case of injury during the study. |  |  |
| I know who to contact if I have any questions about the study in general. |  |  |
| I understand my responsibilities as a study participant. |  |  |
| I wish to receive a summary of the results from the study. | Yes 🞏 | No 🞏 |

**Declaration by participant:**

I hereby consent to take part in this study.

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| Participant’s name: |
| Signature: | Date: |

**Declaration by member of research team:**

I have given a verbal explanation of the research project to the participant, and have answered the participant’s questions about it. I believe that the participant understands the study and has given informed consent to participate.

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| Researcher’s name: |
| Signature: | Date: |