CONSENT FORM

Suture Materials in Carpal Tunnel Syndrome

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| --- | --- |
| I have read the information leaflet for this study | Yes 🗆 No 🗆 |
| I understand that I will receive the same quality of care regardless of my participation in this study | Yes 🗆 No 🗆 |
| I understand that I am not required to participate in this study | Yes 🗆 No 🗆 |
| I understand that if I change my mind at any time, I can withdraw from the study | Yes 🗆 No 🗆 |
| I have further questions about the study | Yes 🗆 No 🗆 |
| I wish to participate in this study | Yes 🗆 No 🗆 |

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| I would like a copy of the study’s results to be sent to me when they become available | Yes 🗆 No 🗆 |
| *Email address for results to be sent to:* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Study Number (Staff to fill out):  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |