**Consent Form**

|  |  |
| --- | --- |
| **Title** | *Virtual Reality for reducing stress in intensive care staff during COVID-19 pandemic**care s care staff* |
| **Short Title** | ***V****irtual* ***R****eality f****Or O****ur* ***M****inds (****VRrOOM****)* |
| **Protocol Number** | 1 |
| **Project Sponsor** | *None* |
| **Coordinating Principal Investigators Principal Investigator** | *Dr Gayatri Athalye-Jape, A/Prof. Shripada Rao**Dr Saumil Desai* |
| **Associate Investigator(s)** | Dr. Ali Fardinpour, Ms. Nicola Van Someren, Ms. Debbie Chiffings |
| **Location**  | *Neonatology, KEMH and PCH**HospHospitals* |

**Declaration by Participant**

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I give permission for my doctors, other health professionals, hospitals or laboratories outside this hospital to release information to King Edward Memorial and Perth Children’s Hospitalsconcerning my disease and treatment only for the purposes of this project. I understand that such information will remain confidential.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the study without affecting my future health care.

I understand that I will be given a signed copy of this document to keep.

|  |
| --- |
|  |
|  | Name of Participant (please print) |  |  |  |  |
|  |
|  | Signature |  |  Date |  |  |
|  |

|  |
| --- |
|  |
|  | Name of Witness\* to Participant’s Signature (please print) |  |  |
|  |
|  | Signature |  |  Date |  |  |
|  |

\* Witness is not to be the investigator, a member of the study team or their delegate. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

**Declaration by Study Doctor/Senior Researcher†**

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

|  |
| --- |
|  |
|  | Name of Study Doctor/Senior Researcher† (please print) |  |  |
|   |  |
|  | Signature |  |  Date |  |  |
|  |

† A senior member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

I understand that, if I decide to discontinue the study treatment, I may be asked to attend follow-up visits to allow collection of information regarding my health status. Alternatively, a member of the research team may request my permission to obtain access to my medical records for collection of follow-up information for the purposes of research and analysis.

|  |
| --- |
|  |
|  | Name of Participant (please print) |  |  |
|  |
|  | Signature |  |  Date |  |  |
|  |

|  |
| --- |
|  |
|  | Name of Study Doctor/Senior Researcher† (please print) |  |  |
|  |  |
|  | Signature |  |  Date |  |  |
|  |

† A senior member of the research team must provide the explanation of and information concerning the research project.

Note: All parties signing the consent section must date their own signature