

Case Report Patient Consent Form

Participant name: _____

Title of article: _____

Author: _____

Authors department and site: _____

Authors contact number: _____

Associate authors: _____

I freely agree to the use of my de-identified information, images, or photographs in the described case report.

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

The nature, purpose and risks of the case report have been explained to me.

I understand the author(s) will make every attempt to ensure my anonymity and that the case report will only include de-identified information/images/photographs.

I understand that the case report may be published in academic journals and/or presented at medical conferences.

I understand that the case report may include photos (Photos will have no identifiable information) that may be published by organisations/industry outside the organisation and presentations at national and international education events.

I understand that I may contact the author at any time prior to publication or presentation to withdraw my consent without it affecting my future health care.

I understand that the case report will undergo ethical review and obtain approval prior to publication or presentation from Central Adelaide Local Health Network Research Services. I also understand that if I wish to speak to someone not directly involved in the case report about my rights as a participant, I may contact CALHN Research Services on 7117 2229.

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

Name of participant: _____

Signature: _____ Date: _____

Name of author: _____

Signature: _____ Date: _____