# MND Register

Full name of the person who has MND: ______________________________

Maiden name ______________________________

Date of Birth ______________________
day month year

current address of the person with MND: ______________________________

______________________________

______________________________

Postcode ______________________________

Telephone ______________________________

Hospital attended: ______________________________

Consultant Name: ______________________________

Who is the GP of the person named above?

Name: ______________________________

Address: ______________________________

| | Please tick one |
|---|---|
| **I would like to be on the Register and receive information on research studies:** | ☐ |
| **I would like to be on the Register but NOT receive information on research studies:** | ☐ |
| **I do not wish to be on the Register:** | ☐ |

Thank you for taking the time to complete this form. Please return this along with the consent form in the envelope provided. Please keep the information sheet provided.

For more information please contact:

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MND Scotland

EUAN MACDONALD CENTRE
Vital research into motor neurone disease

**MND Register – Consent form**

Name of Researchers: Prof Siddharthan Chandran, Dr Suvankar Pal, Shuna Colville

**Please initial box**

1) I confirm that I have read and understood the information sheet (V4.1, 09/10/2017) for the above study and have the opportunity to ask members of the Research Team questions at any time. ☐

2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. Should I withdraw, my medical care or legal rights will not be affected. ☐

3) I understand that my medical notes will be examined over time, information processed and stored securely by responsible individuals from the research team or their regulators.
**No identifiable information will be given to third parties.** ☐

4) I understand that I will not benefit financially from taking part in this study. ☐

5) I agree to take part in the above study. ☐

6) I agree that my health care team can be informed that I am taking part in this study. ☐

7) I agree to receiving information about future research projects which may include clinical trials. This does not commit you to participating in future research. ☐

**OR Complete only if you do not wish research information**

8) I agree to my name being placed on the Register but do not wish to be contacted regarding research studies. ☐

Name of Patient: ______________________________ Date:

Signature: ______________________________

Where the patient is physically unable to sign a proxy can complete the form and sign on their behalf as long as the proxy is satisfied that the patient has understood the information sheet and the consent form.

Name of witness: ______________________________ Date:

Signature of witness: ______________________________

Name of Care Team member: ______________________________ Date:
**(if present)*
Signature ______________________________

MND Scotland

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