Scottish MND Register Registration Form

Details of the person with MND

Full name: ____

Maiden name: ____

Date of birth: ____________________
day month year

Current address: ____

____

Postcode: ____

Telephone: ____

Hospital attended: ____

Consultant name: ____

GP name: ____

GP 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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THE UNIVERSITY of EDINBURGH
Anne Rowling Regenerative Neurology Clinic
EUAN MACDONALD CENTRE Vital research into motor neurone disease

Scottish MND Register – Consent form

Names of researchers: Prof Siddharthan Chandran, Dr Suvankar Pal, Judy Newton.

Please initial box

1) I confirm that I have read and understood the information sheet (V5.0, 21/06/2019) 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 the following 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 ______________________________