



N. Z. Cardiac Inherited Diseases Registry

Consent Form Clinical Information

Co-ordinator: Jackie Crawford
Cardiac Services Level 3
Auckland and Starship Hospital
P.O Box 92024
Auckland
Phone (09) 3074949 Ext. 23634
Fax (09) 3072899
Email: jackiec@adhb.govt.nz
www.cidg.org

English:	I wish to have an interpreter.	Yes	No
Maori:	E hiahia ana ahau kitetahi tangata hei korero Maori ki ahau.	Ae	Kao
Samoaan:	Oute mana'o e iai se fa'amatala upu.	loe	Leai
Tongan:	'Oku fiema'u ha fakatonulea.	lo	Ikai
Cook Island:	Ka inangaro au I tetai tangata uri reo.	Ae	Kare
Niuean:	Fia manko au ke fakaaoga e tagata fakahokohoko vagahau.	E	Nakai

- i. I / we have heard and understood an explanation of the purpose of the Registry I /we or our child/spouse/parents' have been invited to take part in. I /we have read the General Registry Information and Specific Disease related information sheet, about my / our or our child/spouse/parents' specific cardiac inherited disease, and have had my / our questions answered. I / we understand that my / our consent to take part does not alter my / our or our child/spouse/parents' legal rights, or continuing clinical care.
- ii. I / we understand that we may discontinue my / our or our child /spouse/parents' involvement with the Registry at any time and that our current and future medical treatment will continue in the usual manner.
- iii. I / we understand that the Cardiac Inherited Disease Registry, will keep our information confidential and any published medical data will not identify individuals or families.
- iv. I / we give the Cardiac Inherited Disease Registry consent to utilise my / our or our child/spouse/parents' data for the purpose of research into my/our Cardiac Inherited Disease only.

The Cardiac Inherited Disease Registry may collect and store my/our or our child/spouse/parents' clinical information. Should other approved research projects request access to my / our or our child/spouse/parents' clinical information, I / we will be asked for my / our written consent, prior to any information being made available.

Participant Name: *(print and sign)* _____ Sign: _____ Date: _____
(Participant is the person being tested for the condition. If the participant is deceased their full name is still printed in this column)

Parent or Guardian:*(if under 16yrs)* or NOK: _____ Sign: _____ Date: _____
(Next of kin must provide consent if the participant is deceased)

Lead Clinician / Registry Co-ordinator: _____ Sign: _____ Date: _____
(The clinician taking informed consent from the participant)

Role: _____

The N.Z Cardiac Inherited Disease Registry has received Ethical Approval from the N.Z. Multi-centre Ethics Committee:
AKX/02/00/107