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# PATIENT PARTICIPANT INFORMATION AND CONSENT FORM

**Title of Case Report:**

**Clinical Learners:** [Resident physician’s full First and Last]

T: ( ) E:

[Supervisor’s full First and Last Name]

T: ( ) E:

**INTRODUCTION**

I am a medical learner and my supervisor and/or I have recently been involved in providing care to you. As a [resident physician] with the College of Medicine, I am working to better understand and improve care available to patients. I am required to complete a clinical training project as part of my [residency] program.

With your consent, I would like to use the circumstances of your recent medical care and relevant medical history to create my clinical training project because your medical case is interesting and may help educate other healthcare providers. Due to [DESCRIBE WHAT IS UNIQUE ABOUT THIS CASE], information about your case would be educational for other physicians and health care workers. Although you will not benefit directly from allowing your case to be presented, this information will help to advance our understanding of [MEDICAL CONDITION/TOPIC OF STUDY].

During my learning process, I may read your medical chart to review your health status as it relates to my clinical training project. I will have no involvement with your health information once my [residency] is complete.

Your participation is entirely voluntary, and can be revoked at any time. It is up to you to decide whether or not to take part in this project. If you do not wish to participate, you do not have to provide any reason for your decision. You will not lose the benefit of any medical care to which you are entitled or are presently receiving.

**NATURE AND PURPOSE OF CASE STUDY**

I will create a report based on your medical case, and it would be presented [at the University of Saskatchewan’s Internal Medicine Resident (or other specialty if applicable) Research Days. I will compose a written abstract and create a PowerPoint presentation which may contain medical images]. Although there is always a slight risk of loss of anonymity when working with personal health data, your privacy will be respected and all reasonable efforts will be made to protect your information. Your medical information may subsequently also be presented at a conference or submitted for publication in a medical journal.

**CONFIDENTIALITY**

In Saskatchewan, The Health Information Protection Act (HIPA) protects the privacy of your personal health information, and requires I obtain your consent to move further on my educational training project.

I respect your right to privacy and I will ensure your privacy will be maintained. No information that discloses your identity will be released and all identifiers will be generalized or stripped. All of the data used for this study will be de-identified, which means that information such as your name, SHA medical record number, and Saskatchewan Health Services Number will not be included in any reports of the results.

However, my review records and medical records identifying you will be reviewed by me or my preceptor, a physician mentor, to ensure I am using actual patient information and not relying on invention for my project and its findings. The results of this case study may be presented in a scientific meeting or published, but your identity will never be disclosed.

**QUESTIONS**

If you have any questions or concerns about this case study, you should contact me or my supervisor at the telephone number or email address provided on page one.

**STATEMENT OF PATIENT CONSENT**

I have read, or had read to me, the above information before signing this consent form.

I have had time and opportunity to ask questions and all my questions have been answered.

If I do not participate or if I discontinue my participation in this project I will not be penalized, my future medical care will not be affected.

This agreement is for the sole purpose of the disclosure for my medical information be used for de-identification purposes specific to this research project, and does not extend to any other use or subsequent project(s).

I understand I will receive a signed copy of this consent form.

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Print name of patient or substitute decision maker (SDM)

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Signature of patient or SDM Date (dated by patient or SDM)

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Print name of person explaining consent

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Signature of person explaining consent Date (dated by person explaining consent)