

ESMO-CoCARE Patient Consent Form

Sponsor: **Institute Curie, 26 rue d'Ulm, 75248, Paris cedex 05 – FRANCE (<https://institut-curie.org/>)**
Principal Investigator: *[will be added hospital specific]*
Hospital Site: *[will be added hospital specific]*

I hereby confirm that I had been informed by the study investigator about this registry study. I have received, read, and understood the Patient Information Leaflet regarding this study

I understand that participation in this study will not influence or change the treatment(s) I receive. I understand that participation in this study may be of no benefit to me personally.

I understand that personal details regarding my age, cancer diagnosis, recent treatments, and other health conditions will be collected and stored on a secure database held by ESMO-CoCARE and located in Switzerland; however ESMO-CoCARE will not be able to identify me from my data.

I understand that I may, at any point, without prejudice, withdraw my consent from the participation in this study, and decide to 'opt out'. I understand if I wish to withdraw from this study, that I do not need to provide a reason for doing so, and that doing so will not affect my treatment or relationship with my treating team in any way.

I have had sufficient opportunity to discuss any concerns or queries I have about participating in this study with family, friends or other advocates, as well as with the study team.

I consent to take part in this study and for my data to be processed within this study. I am not giving up any of my legal rights by consenting to participate in this study

Consent is given: in writing verballyⁱ by e-mailⁱⁱ

Patient Name: _____
(Block Capitals)

Patient Signature: _____ Date: ____/____/____

Witness (if applicable)
Name: _____
(Block Capitals)

Signature: _____ Date: ____/____/____

Hospital heading

If signed on behalf of patient

Representative Name: _____

(Block Capitals)

Representative Signature: _____

Relationship to patient: _____ Date: ____/____/____

Details of Physician/Nurse obtaining consent

Name: _____ MCRN/PIN: _____

(Block Capitals)

Signature: _____ Date: ____/____/____

ⁱ Please record the date and time consent was received in the patient chart

ⁱⁱ Please print and file copy of email in patient chart