Contact for study information:

Dr Angela Lucas-Herald

Royal Hospital for Children,

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Contact for independent study advice:

Dr Martina Rodie

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**VASCULAR PHENOTYPE OF BOYS WITH SUSPECTED HYPOGONADISM (GO-VASC STUDY)**

**Consent form for participant**

**Study number:**

**Name of participant (block capitals):**

**Please**

**initial**

**box if you agree**

|  |  |  |
| --- | --- | --- |
| 1 | I confirm that I have read and understood the Information Sheet for Cases for the above study dated 19/7/17 (Version 2.0). I have had the opportunity to consider the information, ask questions and had these questions answered to my satisfaction. |  |
| 2 | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my medical care or legal rights being affected. |  |
| 3 | I understand that my GP will be informed that I am participating in this study. |  |
| 4 | I allow access for the research team and sponsor representatives to my medical records and patient identifiable information. |  |
| 5 | I understand that if anything unexpected is demonstrated in my tests, I will be referred to the appropriate specialist for further investigations. |  |
| 6 | I agree to take part in this study. |  |
| 7 | I agree to a blood sample being taken for genetic analysis. |  |
| 8 | I agree that the anonymised results from this study could be used for future ethically approved studies. |  |

Name:

Signature:

Name of witness to signature:

Signature of witness to signature:

Date:

**Thank you for your help.**

**You will receive a copy of this form.**