PATIENT/PARTICIPANT CONSENT FORM

Study title: *Development and Establishment of a Register of Patients with Epilepsy caused by Genetic Mutations – The Epilepsy Associated Gene Ready Register (EAGER).*

I have read and understood the **Information Leaflet** about this research register. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	**Yes** ☐	**No** ☐
I understand that I don't have to take part in this research register and that I can opt out at any time. I understand that I don't have to give a reason for opting out and I understand that opting out won't affect my future medical care.	**Yes** ☐	**No** ☐
I am aware of the potential risks, benefits and alternatives of this research register.	**Yes** ☐	**No** ☐
I give permission for researchers to look at my medical records to get information. I have been assured that information about me will be kept private and confidential.	**Yes** ☐	**No** ☐
I have been given a copy of the Information Leaflet and this completed consent form for my records.	**Yes** ☐	**No** ☐
I consent to take part in this research study having been fully informed of the risks, benefits and alternatives.	**Yes** ☐	**No** ☐
I give informed explicit consent to have my data processed as part of this research register.	**Yes** ☐	**No** ☐
I consent to be contacted by the research nurse as part of this research register.	**Yes** ☐	**No** ☐

FUTURE CONTACT [please choose one or more as you see fit]		
OPTION 1: I consent to be entered onto the EAGER Register **AND** re-contacted by the research nurse about possible future precision therapies or clinical trials **related** to the current register for which I may be eligible.	**Yes** ☐	**No** ☐
OPTION 2: I consent to be entered onto the EAGER Register but **NOT** re-contacted by the research nurse about possible future precision therapies or clinical trials **related** to the current register for which I may be eligible.	**Yes** ☐	**No** ☐

Patient/Participant Name (Block Capitals)	Patient/Participant Signature	Date

Translator Name (Block Capitals)	Translator Signature	Date

Legal Representative/Guardian Name	Legal Representative/Guardian Signature	Date

To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above patient the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

Name (Block Capitals)	Qualifications	Signature	Date