PARTUM

CONSENT TO CONTACT FOR RESEARCH PURPOSES

You authorize your health service provider to disclose your name, telephone number and email address to the research team for the purpose of being contacted to learn more about the PARTUM trial.

Every effort will be made to safeguard your contact information. Although access to this information will be limited, there is a small chance that this information could be inadvertently disclosed or inappropriately accessed.

You have been made aware of the reasons why the contact information is needed and the risks and benefits of consenting or refusing to consent.

This consent is effective immediately. Your consent to be contacted can be revoked by you at any time.

You are being invited to give consent for Dr. A.K. Malinowski or a qualified member of her study team, to contact you in the future to invite you to participate in a research study.

After reading the front of this card, **are you willing to be contacted to learn more about the pilot PARTUM trial?** (Circle One)

YES NO

If yes, you will be contacted at a later date. Please include your contact information below.

Telephone: _____ E-mail: _____

Patient's Name: _____

Patient's Signature: _____

Date (DD/MMM/YYYY): _____

Healthcare Provider's Name and Signature: _____