

Consent for blood and urine collection, storage and analysis

Please cross (☒) each of the following statements to which you agree:

Yes <input type="checkbox"/> No <input type="checkbox"/>	I confirm that I have read and understood the information about blood <u>and urine</u> sampling. I understand that providing a blood <u>and urine</u> sample is optional, and I am free to participate in the trial without agreeing to my blood or urine being taken.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I agree to the samples being used for immediate measurements of glucose control, lipids (<u>cholesterol</u>) and <u>kidney function</u> , and for relevant results to be provided to my general practitioner.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I agree that samples of my blood <u>and urine</u> may be stored for future biochemical tests (other than genetic tests) to help understand the effects of the study treatment and the causes of diabetes and circulatory disease. This is on the understanding that the investigations will be for medical research only and my results will be kept confidential.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I agree that samples of my blood may be stored for future genetic tests to help understand the effects of the study treatment and causes of diabetes, and circulatory disease. This is on the understanding that the investigations will be for medical research only and my results will be kept confidential.

PRINTED name of participant

Signature

 / /

Date

THANK YOU FOR YOUR HELP

To be completed by the practice nurse (in blue or black ink). If possible, please record:

Weight:	<input type="text"/> <input type="text"/> <input type="text"/> Kgs OR <input type="text"/> <input type="text"/> Stones & <input type="text"/> <input type="text"/> lbs
Height:	<input type="text"/> <input type="text"/> <input type="text"/> Cms OR <input type="text"/> Feet & <input type="text"/> <input type="text"/> inches
Blood Pressure:	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Pulse: <input type="text"/> <input type="text"/> <input type="text"/> beats/min
Has a blood sample been obtained?	Yes <input type="checkbox"/> No <input type="checkbox"/> Is a urine sample provided? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date blood sample was taken:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
Nurse's Name	<input type="text"/>
Nurse's Signature	<input type="text"/>
Contact Telephone Number	<input type="text"/>

Please ensure that the participant has read and signed the consent above and return the completed form with the blood and/or urine sample to the ASCEND coordinating centre in the Freepost envelope provided. **Please mail it today** as delays in the post can affect the measurements. If you require any further information or help, please call the ASCEND coordinating centre on Freefone 0800 585323. A copy of this form will be sent to the participant.