Consent Form – Patient Parent (Liverpool)

Title:	Supporting Children with Complex Feeding Difficulties
Short Title:	SuCCEED Study Group
Protocol Number:	LNR/17/SCHN/340
Project Sponsor:	Sydney Partnership in Health Education, Research and Enterprise (SPHERE)
Coordinating Principal Investigator:	Dr Christopher Elliot
Associate Investigators:	Ann Dadich, Nick Hopwood, Susan Woolfenden, Valsa Eapen, Khadeejah Moraby

Declaration by Parent

I have read the Participant Information Sheet or someone has read it to me in a language that I understand. I understand the purposes, procedures and risks of the research described in the project. I have several options, including not participating at all. I have ticked below to indicate my consent:

☐ I give permission for **video recording of my appointment** with my child at the feeding clinic, Liverpool Hospital

☐ I consent to participate in a **one-hour group discussion** with other parents, where we will look together at excerpts from our video-recorded appointments, to help identify areas for improvement as aspects we think work well. I can request this on a 1:1 basis if I prefer, and know how to ask for this

☐ I consent to participate in a **one-hour group discussion** with other parents, where we will test a newly developed website aimed to help parents of children with feeding difficulties.

I understand that I can change my mind about the video group and website testing at a later date if I wish.

I have had an opportunity to ask questions and I am satisfied with the answers I have received. I freely agree to participating in this research project as described and understand that I am free to withdraw at any time during the research project without affecting my child's or my future health care. I understand that I will be given a signed copy of this document to keep.

At the end of the project, a report will be produced which can be shared with you.

Name of Child (*please print*): _____

Parent Name: _____ **Date:** _____

Signature: _____ **Date:** _____

I would **like** to receive a copy of the study report **OR** I would **not like** to receive a copy of the report:
Email (*optional*): _____

Mail address (*optional):* _____

Under certain circumstances (see Note for Guidance on Good Clinical Practice CPMP/ICH/135/95 at 4.8.9) a witness to informed consent is required.*

Name of Witness* to Parent's / Guardian's Signature (*please print*): _____

Signature of Witness: _____ Date: _____

* The Witness is not to be the investigator, a member of the study team or their delegate. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witnesses must be over 18 years of age.