

**The ICECAP COVID-19 study**

**Authorisation Form for Medical Research and Education**

Name of Deceased……………………………………………………………………………………………………………………………

Date of Birth……………………………………………………………Date of Death…………………………………………………..

**Please initial boxes**

1. I confirm that I have read and understood the information sheet (30th March 2020; Version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that taking part is voluntary and that I am free to withdraw

 at any time without giving any reason, without any legal rights being affected.

1. I authorise that the tissue samples retained at the time of the post-mortem examination may be used for all ethically approved medical research.
2. I authorise that additional small tissue samples may also be taken, retained

 and used for all ethically approved medical research.

1. I confirm that to the best of my knowledge, neither the deceased nor other

members of the family had any objection to a post-mortem and collection of

tissue samples for research.

1. I authorise that the tissue samples retained may be used for:

 research purposes

genetic research

1. I agree that tissue may be stored as protein, RNA and/or DNA for analysis

 in future studies.

1. I agree to my relative’s GP being informed of their participation in the study.
2. I agree that data may be collected and stored on a secure database
3. I authorise that the tissue samples may be used by researchers in the

 commercial sector e.g. pharmaceutical companies, to help with the

 development of new drug treatments and diagnostic tests which may

 benefit human health.

1. I authorise that the tissue bank may keep indefinitely the tissues donated for

medical research and dispose of them lawfully when the research is complete

 or they are no longer usable.

1. I authorise that The University of Edinburgh research team may gather any

relevant medical information relating to my deceased relative from the medical records and any NHS electronic medical records.

1. I understand that any information collected will be treated as confidential and

 made available to researchers only in a form which preserves anonymity.

1. I understand that I will not benefit financially if any research leads to the

 development of a new treatment or medical test in the future.

Name (print)……………………………………………………………. Signature…………………………………………………………….

Relationship to deceased………………………………………….………………… Date…………………………………………………

**Statement by the Witness**

I confirm that I have discussed with…………………………………………..………….................... (named above)

the enrolment of……………………………………………………………….. (deceased) for medical research and education.

Witness (print)……………………………………………………………. Signature…………………………………………………........

Position……………………………………………………......................Date………………………………………………………………

**Thank you for agreeing to participate in this project**

**If you have any queries regarding this form please contact:**

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