<<print on local headed paper>>

INFORMED CONSENT FORM

AFLOAT STUDY

Antibiotics For uncomplicated Lower respiratory tract infection in Older AdulTs.

Patient Name:

Patient ID Number:
(to be obtained post randomisation))

1. I confirm that I have read (or had read to me) and understood the Patient Information Sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions, and I have had these answered satisfactorily.	**Please initial in the box** INITIAL
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	INITIAL
3. I understand that relevant sections of my medical notes and the data collected during this trial may be looked at by the necessary staff members from my GP practice, the Southampton Clinical Trials Unit, the University of Southampton, and Regulatory Authorities, or from the NHS Trust where I am taking part in this research. I give permission for these individuals to look at my records.	INITIAL
4. I understand that the information collected about me could be used to inform future research and may be shared anonymously with other researchers.	INITIAL
5. I agree to my pseudo-anonymised (non-identifiable) data, managed by the University of Southampton, being held on servers located in the UK, EU and USA. Access will be strictly controlled. All applicable Data Protection legislation will be abided by.	INITIAL
6. I agree to my consent form and my contact details, including name, telephone number, email, and home address, being shared with the AFLOAT research trial team so they may check my consent and contact me for study	INITIAL

procedures. I understand that my details will be stored securely and will not be revealed to anyone outside of the study team	
7. IF RELEVANT: I agree for my General Practitioner to be informed of my participation in the study.	INITIAL
8. OPTIONAL: I agree to have a finger prick blood test (to measure inflammation in my body; a test called CRP)	Yes ☐ No ☐
9. OPTIONAL: I would like to be informed of the results of the AFLOAT Trial.	Yes ☐ No ☐
10. I agree to take part in the AFLOAT Trial.	INITIAL

Name of participant		Signature	Today's Date
			/ /
Name of person receiving consent	Role of person receiving consent	Signature	Today's Date
			/ /

REMINDER FOR THE RESEARCH TEAM:

When completed, the original signed consent form is to be stored in Investigator Site File, one copy given to the patient, one copy filed in the patient's medical records, and one copy to be sent to SCTU via secure email: afloat@securemail.soton.ac.uk