Hugh Sinclair Unit of

Human Nutrition

Department of Food and

Nutritional Sciences

University of Reading  
PO Box 226   
Reading RG6 6AP

Phone +44 (0)118 378 7771

NAME OF STUDY PRINCIPLE INVESTIGATOR

PHONE NUMBER OF PI

EMAIL OF PI

**Consent Form for STUDY NAME**

**Please initial boxes**

1. I confirm that I have read and understand the Participant Information Sheet dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_for the above study, which was explained by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I authorise the investigator to inform my General Practitioner if any abnormal results are found in relation to my screening results. I will be informed when this happens.
4. I have received a copy of this Consent Form and of the accompanying Participant Information Sheet.
5. I consent to an initial blood sample being taken for screening purposes, followed by a series of blood samples throughout the study at the times indicated on the accompanying Participant Information Sheet.
6. I understand that this study has been reviewed by the University of Reading Research Ethics Committee and has been given a favourable ethical opinion for conduct.
7. I consent to the use of my samples for genetic testing in ethically approved research.

**Participant details**

Name of Participant: Date of Birth:

Signature: Date:

Address of Participant:

Telephone number:

**General Practitioner (GP) details**

Name:

Address:

Telephone:

**Witnessed by**

Name of researcher taking consent:

Signature: Date: