

Gynaecology Diagnostic and Treatment Unit
Clinic 3 Lower Ground Floor EGA
235 Euston Road
London NW1 2BU
Direct Line: 020 3447 6518
Fax: 020 3447 6598

Consent Form

Email: simrit.nijjar@nhs.net
Website: www.uclh.nhs.uk

Study Title: Intramural pregnancy registry

Chief Investigator: Professor Davor Jurkovic
Principal researcher: Dr Simrit Nijjar

Please **initial** boxes as appropriate

- | 1. I confirm that I have read and understood the information sheet dated 26.11.2024 (Version 1.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <table border="1"><thead><tr><th>Yes</th><th>No</th></tr></thead><tbody><tr><td>INITIAL</td><td>INITIAL</td></tr></tbody></table> | Yes | No | INITIAL | INITIAL |
|--|---|-----|----|---------|---------|
| Yes | No | | | | |
| INITIAL | 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. | <table border="1"><thead><tr><th>Yes</th><th>No</th></tr></thead><tbody><tr><td>INITIAL</td><td>INITIAL</td></tr></tbody></table> | Yes | No | INITIAL | INITIAL |
| Yes | No | | | | |
| INITIAL | INITIAL | | | | |
| 3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from University College London, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. | <table border="1"><thead><tr><th>Yes</th><th>No</th></tr></thead><tbody><tr><td>INITIAL</td><td>INITIAL</td></tr></tbody></table> | Yes | No | INITIAL | INITIAL |
| Yes | No | | | | |
| INITIAL | INITIAL | | | | |
| 4. I understand that I will not receive financial compensation for taking part in this study. | <table border="1"><thead><tr><th>Yes</th><th>No</th></tr></thead><tbody><tr><td>INITIAL</td><td>INITIAL</td></tr></tbody></table> | Yes | No | INITIAL | INITIAL |
| Yes | No | | | | |
| INITIAL | INITIAL | | | | |
| 5. I understand that relevant sections of any of my medical notes and data will be transmitted for research purposes to the intramural pregnancy registry. | <table border="1"><thead><tr><th>Yes</th><th>No</th></tr></thead><tbody><tr><td>INITIAL</td><td>INITIAL</td></tr></tbody></table> | Yes | No | INITIAL | INITIAL |
| Yes | No | | | | |
| INITIAL | INITIAL | | | | |
| 6. I agree to take part in the above study. | <table border="1"><thead><tr><th>Yes</th><th>No</th></tr></thead><tbody><tr><td>INITIAL</td><td>INITIAL</td></tr></tbody></table> | Yes | No | INITIAL | INITIAL |
| Yes | No | | | | |
| INITIAL | INITIAL | | | | |
| 7. I agree to my anonymised data and/or results being used for future ethically approved research. | <table border="1"><thead><tr><th>Yes</th><th>No</th></tr></thead><tbody><tr><td>INITIAL</td><td>INITIAL</td></tr></tbody></table> | Yes | No | INITIAL | INITIAL |
| Yes | No | | | | |
| INITIAL | INITIAL | | | | |

Optional:

I consent to be contacted in the future regarding research related to intramural pregnancy.

Yes	No
INITIAL	INITIAL

Study ID:

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Name of participant	Signature of participant	Date (dd/mm/yy)

Name & role of person taking consent	Signature of person taking consent	Date (dd/mm/yy)

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes