



**Study ID number:**

**CONSENT FORM V2\_24.03.2015**

**Study title:** Prospective Register Of patients undergoing repeated Office and Ambulatory Blood Pressure Monitoring (PROOF-ABPM)

**REC reference:**

**Chief Investigator:** Dr James Sheppard

*Please initial  
each box*

1. I confirm that I have read and understood the participant information sheet V2\_24.03.2015 for the above study and had the opportunity to ask questions.
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.
3. I understand that relevant sections of my medical notes and data, collected during the study, may be looked at by individuals from the University of Oxford, from regulatory authorities or from the NHS Trust. I give permission for these individuals to have access to my records.
4. I understand that information held by the Department of Health National data centre may be used to allow collection of information about the state of my health in the future.
5. I understand that the information collected about me in this study may be shared anonymously with other researchers to support other research in the future.
6. I agree to take part in this study.

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Name of participant (please print) \_\_\_\_\_ Date \_\_\_\_\_ Participant signature \_\_\_\_\_

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Participant address \_\_\_\_\_ Post code \_\_\_\_\_

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Participant date of birth      /      /      Name of GP/nurse referring patient to the study \_\_\_\_\_

**If you sign this form within the clinic or practice**, please hand the white and green copies to the Doctor/Nurse/Reception and keep the yellow copy for yourself.

**If you sign this form at home**, please put the white and green copies in the addressed envelope and send it back to the hospital/practice, the yellow copy is for you to keep.