



## Platform Adaptive trial of NOvel antivirals for eArly treatMent of covid-19 In the Community: PANORAMIC

REC Number: 21/SC/0393

IRAS Number: 1004274

Chief Investigator: Professor Christopher Butler

Participant ID:

### CONSENT FORM

Thank you for completing the screening questionnaire, you have passed the screening stage for the trial.

Please read the [Participant Information Sheet](#) if you haven't already done so, and if you are willing to participate please select 'Yes', TYPE your FIRST and LAST names below and then click Submit

**If you agree, please select 'Yes' to confirm that you have read and understood the following:**

		YES	NO
1	I confirm I have read and understood the information sheet version number ____ - _____ dated ____ / ____ / _____ for the above study. I have had the opportunity to ask questions and had these answered satisfactorily.		
2	I understand my participation is voluntary and that 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 if I chose to withdraw data already collected will continue to be used and I or my GP may be contacted if there are further questions regarding side-effects from trial treatments.		
4	I understand that I will be randomised to receive either: standard care plus an antiviral treatment or standard care, and that I will not be able to choose which I will receive.		
5	I understand that relevant sections of my GP and hospital medical notes and data collected during the study may be looked at by members of the research team and individuals from University of Oxford, both during and for up to 10 years after the scheduled follow-up period. It may also be reviewed by relevant people from regulatory authorities and from the NHS Trust(s). I give permission for these individuals to have access to my records		
6	I understand that my date of birth and NHS number will be shared with NHS Digital to enable them to supply the study team with additional healthcare data about me, which is relevant to the trial. The data supplied by NHS Digital is linked by the research team to the data collected during my participation in the trial. I am free to withdraw my consent for data linkage with NHS Digital at any time and it will not affect my ongoing care.		
7	I understand that members of the research team may view my Summary Care Record (SCR) to check my medication, allergies, adverse reactions and additional information to make sure that it is safe for me to take trial medication. I give permission for these individuals to access my SCR for this purpose.		



8	I consent to being contacted by the research team for the purposes of trial follow up (up to 6 months) and I understand that this will require me to provide my contact details to the research team.		
9	I consent to my GP and/or Care Home being informed of my participation within the study and I understand that the trial team may contact my GP about my ongoing participation in the trial.		
10	I understand that the information collected about me may be shared in a form that cannot identify me with commercial companies to support the licensing of trial treatments, within the UK and abroad.		
11	I agree to take part in the trial.		
	<b><i>For participants capable of being pregnant (Regardless of current contraception methods) (to show only for those who meet this criteria in the screening form)</i></b>		
12	I agree to taking a pregnancy test prior to taking the trial treatment		
	<b><i>ADDITIONAL (optional, not required for study participation)</i></b>	<b>YES</b>	<b>NO</b>
13	<i>I agree to provide the research team with the contact details of my Trial Partner. I confirm my Trial partner is aware of their role and willing to answer questions.</i>		

**If you are the participant completing the consent form, please provide your signature below**

Participant Signature:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

**If the participant has provided verbal consent, but they are unable to complete the consent form due to lack of online access, too unwell, too frail or consent is completed via the telephone (the participant must have capacity), please provide:**

1. Name of the participant

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

2. Signature of person completing the form

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Role: Study Partner/Trial Team Member/Health Care Professional



Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

**If participant lacks capacity to give consent:**

I have read the information (or had it read to me), had an opportunity to ask questions and signed the *Legal Representative Letter*. I understand that the patient will be asked to confirm their consent as soon as they have the capacity to do so and that if they wish, they will be able to withdraw from the trial without it affecting their medical care.

**Participant:**

Name: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

I believe that if they were able to, the patient would wish to take part in this trial.

.....	.....	...../...../.....
PRINTED name of Legal Representative	Signature	Today's date

.....  
Relationship to participant (as confirmed in the signed *Legal Representative Letter*)

You will have the opportunity to print a copy of the consent form after submission. Please contact the study team if you would like a copy sent to you

**By submitting, I confirm that I am the person whose name is stated above.**

**If you have any questions about this or any other part of the study please contact the study team:**

Tel: 08081 560017

Email [panoramic@phc.ox.ac.uk](mailto:panoramic@phc.ox.ac.uk)