

CONSENT FORM

Title of Study: **Functional annotation of psoriasis susceptibility alleles**

Ethics Ref:

Date of Approval:

Study ID:

Name of participant: _____ Study Number:

Name of Chief Investigator: Professor Jonathan Barker

Please Initial box

1. I confirm that I have read and understand the Patient/Participant Information Sheet for the above study and have had the opportunity to ask questions.
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.
3. I understand that sections of any of my medical notes may be looked at by hospital staff and members of regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.
4. I agree to donate samples of my **blood/saliva/skin/hair** (*delete as appropriate*), and for personal data to be collected for the purposes of this research and for this material to be stored on a secure database in an anonymised manner for this study.
5. I agree to personal information from which I can be identified being held by the research team at St. John's Institute of Dermatology in a secure database, but held separately from my clinical information.
6. I agree to the anonymous storage of my personal data and materials following the completion of this study for future studies in psoriasis in the research bio-bank at St. John's Institute of Dermatology, Guy's and St Thomas' NHS Trust: Ethics Approval Ref: 07/H0712/106; HTA License number 12521.

Please check "Yes" or "No" to item 7. You may participate in this study regardless of your response to the below statement.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 7. I agree to be contacted in the future for the purpose of requesting consent for further clinical investigation and biological samples from me. I understand that this part of the study is entirely optional. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. I agree to take part in the above study. | | |

Signature

Name of participant

Date

Signature

Name of researcher

Date

Signature

Name of Investigator

Date

1 copy for participant, 1 copy for medical/research notes & 1 copy for department.

Date: 23/10/14, Version 1