Community Health Navigators (CHNs) transitioning care into the community

**PARTICIPANT CONSENT FORM**

I, ...................................................................................................................................... *[name]*

of

..............................................................................................................................…….

[*address]*

have read and understood the Information for Participants on the above-named research study.

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, or discomfort and of their implications as far as they are currently known by the researchers.

I understand that this study is a randomised control trial where potential participants are allocated by chance to one of two groups, and I agree to this.

I understand that my participation in this study will allow the researchers and others, as described in the Information for Participants, to have access to my medical record, and I agree to this.

I understand staff members of this study may contact my general practitioner, pharmacist, allied health provider, community health services, aged and/or home care services and other health and/or social care providers

I understand that, during the course of this study, my **de-identified** medical records may be accessed by the National Health and Medical Research Council who funds this study, by regulatory authorities or by the Human Research Ethics Committee approving the research, in order to check results and make sure that the study is being carried out correctly.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely choose to participate in this study and understand that I can withdraw at any time.

I understand that the Sydney Local Health District software license for REDCap (Research Electronic Data Capture) and Centre for Primary Health Care (CPHCE) at the University of New South Wales will be used to manage the collection and storage of my research data. I also understand that the research study is strictly confidential, and only group data and de-identified data will be published.

I consent to the future use of any data I provide for research purposes. I understand that before future researchers can use any data I provide, they must seek additional ethics approval: YES / NO *(please circle one)*

I would like to receive a copy of the study results: YES/ NO *(please circle one)*

(If, YES) my postal address is:

**..................................................................................................**

*(as above if applicable)*

(If, YES) my email address is:

**..................................................................................................**

I hereby agree to participate in this research study.

**NAME: .........................................................................................................**

**SIGNATURE: ....................................................................... DATE: .........................**

**NAME OF WITNESS: ...............................................................................................**

**SIGNATURE OF WITNESS: ....................................................DATE …………………**

PO Box M30

Missenden Road, NSW 2050 Email [slhd-esu@health.nsw.gov.au](mailto:slhd-esu@health.nsw.gov.au) [www.slhd.nsw.gov.au](http://www.slhd.nsw.gov.au/)

Sydney Local Health District

ABN 17 520 269 052

Level 11 North, King George V Building

83 Missenden Rd

CAMPERDOWN, NSW, 2050

Tel 612 9515 9600 Fax 612 9515 9610