




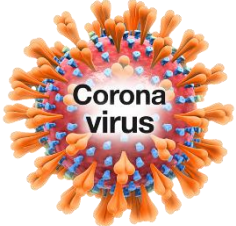











IDS-TILDA Wave 4 - CAPI

Please read the information below. Then tick the boxes and sign this consent form if you wish to take part in this fourth wave of the study.

I agree with the following statements: ✓			
		Yes	No
	I have read, or had read to me, the information booklet about this study.	<input type="checkbox"/>	<input type="checkbox"/>
	The researcher has explained to me what the study is about.	<input type="checkbox"/>	<input type="checkbox"/>
	Any questions that I had were answered.	<input type="checkbox"/>	<input type="checkbox"/>
	I know who to contact if I have any more questions.	<input type="checkbox"/>	<input type="checkbox"/>

	<p>I understand that I will be asked questions about my:</p> <ul style="list-style-type: none"> • life • health • work • friends, and • things I like to do 	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>
	<p>I know that I will be asked questions about Coronavirus.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>
	<p>I know that it is my choice to take part in this study.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>
	<p>I know that I do not have to answer questions I do not feel happy with.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>
	<p>The researcher can ask the HSE what medicine I take.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>
	<p>I know that I can stop taking part in this study when I want to.</p> <p>I do not have to give a reason.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>

	<p>I understand that all information I give during this study will be kept safe and private.</p>	<p>Yes</p> <input data-bbox="1150 315 1238 387" type="checkbox"/>	<p>No</p> <input data-bbox="1289 315 1377 387" type="checkbox"/>
	<p>I know that I will not be named in any reports.</p>	<p>Yes</p> <input data-bbox="1150 645 1238 716" type="checkbox"/>	<p>No</p> <input data-bbox="1289 645 1377 716" type="checkbox"/>
	<p>I know that there are no known risks with this study.</p> <p>And that there are no direct benefits to me from this study.</p>	<p>Yes</p> <input data-bbox="1150 987 1238 1059" type="checkbox"/>	<p>No</p> <input data-bbox="1289 987 1377 1059" type="checkbox"/>
	<p>I know this study will continue and I will be contacted again in three years about consenting to take part in the next Wave.</p>	<p>Yes</p> <input data-bbox="1150 1417 1238 1489" type="checkbox"/>	<p>No</p> <input data-bbox="1289 1417 1377 1489" type="checkbox"/>
	<p>I am happy to take part in this study.</p>	<p>Yes</p> <input data-bbox="1150 1807 1238 1879" type="checkbox"/>	<p>No</p> <input data-bbox="1289 1807 1377 1879" type="checkbox"/>

Your Consent

Your name: _____

Your phone number: _____

Your address: _____

Please sign your name: _____



Date: _____

THE PERSON SUPPORTING YOU

I have supported the person named above to fill out this form. I believe they understand the information and have freely agreed to take part in this study.

Print name: _____

Relationship to the person named above: _____

Phone number: _____

Signature: _____

Date: _____

OFFICE USE ONLY

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

RESEARCHER'S SIGNATURE _____

Date: _____