<<Printed on

Trust Headed Paper>>

**M**echanism of **B**etablockade **O**n bacterial translocation in **P**ortal hypertension

(MBOP study)

**Informed Consent Form – MBOP**

**Site name**:……………………………… **Principal Investigator**:………………………………

**P**

Participant Identification Number (PIN):

 ***Please insert your initials in each box to confirm consent* ↓**

1. I confirm that I have read and understood the participant information sheet, 4.0, 31 MAY 2023, for the **MBOP study of the BOPPP Trial.** I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.
2. I understand that 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. I understand that data collected up to my time of withdrawal may still be used.
3. I give permission for the following investigations
	1. Blood sampling for immune/cytokine/metabolic profiling, DNA analysis………………
	2. Saliva sampling for DNA analysis……………………………………………………………………………
	3. Faeces sampling for DNA analysis………………………………………………………………………….
	4. Ultrasound of the spleen……………………………………………………………………………………….
4. I agree that at the end of the research unused samples will be stored anonymously in the King’s College Hospital Liver Tissue Research Bank.
5. Information collected that identifies me by name, e.g. consent forms as well as contact address and email, will be transferred from where it is collected and stored at King’s College Hospital during the trial and at a specialist archiving facility, in compliance with current regulations, after the trial. I agree to the transfer and storage of this information.
6. I agree to take part in the **MBOP study**.

***To participate in MBOP you MUST consent to points 1-6 above and initial the corresponding boxes.***

|  |  |  |
| --- | --- | --- |
| Name of participant………………………………………………….. | Date………………………………………………….. | Signature………………………………………………….. |
| Name of person taking consent ………………………………………………….. | Date………………………………………………….. | Signature………………………………………………….. |

***Original to be filled in the ISF; One copy for the participant; One copy for the patients’ hospital record***