

## Consent form

For a patient's consent to publication of images and/or information about them in IDDF publications.

Name of patient: \_\_\_\_\_

Relationship to patient  
(if patient not signing this form): \_\_\_\_\_

Provisional title of article in  
which Material will be included: \_\_\_\_\_

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### CONSENT

I \_\_\_\_\_ [PRINT FULL NAME] give my consent for the Material about me/the patient to appear in IDDF publications.

I understand the following:

1. The Material will be published without my/the patient's name attached, however I understand that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - for example, somebody who looked after me/the patient or a relative - may recognise me/the patient.
2. The Material may show or include details of my/the patient's medical condition or injury and any prognosis, treatment or surgery that I have/the patient has, had or may have in the future.
3. The article may be published in the IDDF programme book and/or the IDDF website.
4. I/the patient will not receive any financial benefit from publication of the article.

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Email address: \_\_\_\_\_

Telephone no: \_\_\_\_\_

Address: \_\_\_\_\_

*If signing on behalf of the patient, please give the reason why the patient can't consent for themselves (e.g. patient is deceased, under 18 or has cognitive or intellectual impairment).*

Reason: \_\_\_\_\_

**Details of person who has explained and administered the form** to the patient or their representative (e.g. the corresponding author or other person who has the authority to obtain consent).

Signature: \_\_\_\_\_ Print name: \_\_\_\_\_

Position: \_\_\_\_\_ Institution: \_\_\_\_\_

Email address: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone no: \_\_\_\_\_

Address: \_\_\_\_\_