**Case Report Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Principal Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Co-Investigator(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The reporting team has no conflicts of interest to declare related to this case report.**

**Why am I being asked to participate?**

You are being invited to participate in this case report because we were involved with your medical care at Kingston Health Sciences Centre for [list condition or treatment] and/or during [specify procedure as applicable].

**Why is this report being done?**

The purpose of this case report is to communicate why this case was unusual because it was identified that [include information as to why this case needs to be published].

**What will happen if I choose to participate?**

You do not need to do anything other than provide informed consent. There will be no additional medical visits or tests.

**How will my privacy be protected?**

This case report will be limited to the collection of information from your medical record [add any other data sources]. All information collected about you will be de-identified, which means any information that could identify you will be removed (e.g., name, OHIP number, etc.). Any information gathered will be kept confidential and not shared with anyone else except with members of the reporting team unless required by law. Data will be stored securely on hospital servers separate from hospital records for 5 years, after which it will be destroyed [OR include plans for storage and retention of data]. The reporting team plans to publish the results of this case report in academic journals and present them at conferences [OR include dissemination plans] but you will not be identified.

**What are the Risks and Benefits of participation?**

There are no risks and no direct benefits to your participation, but we hope that the information learned from this case report can be used in the future to help other people with a similar disease and/or health condition.

**What if I want to end my participation?**

You can change your mind about participation at any time prior to publication of the case report. You do not need to give a reason and withdrawing will not have any effect on your current or future medical care.

**What if I have Questions?**

If you have any questions about the case report, or if you would like to withdraw your consent please contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

For ethics concerns, please contact the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (HSREB) at 1-844-535-2988 (Toll free in North America) or email [HSREB@queensu.ca](mailto:HSREB@queensu.ca).

[if you are a student/resident/fellow, provide Supervisor’s contact information]

By signing below, I am verifying that:

* Participation is completely voluntary and whether I decide to provide consent, or not, will have no influence on current or future medical care at this institution
* I will not receive monetary compensation for the publication of the case report
* I understand that the medical case will be published, and I will not be identified
* I have not waived any legal rights by consenting to participate in this case report

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Signature of Participant/Guardian/ PRINTED NAME Date

Substitute Decision-Maker

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Conducting PRINTED NAME & ROLE Date

the Consent Discussion

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Signature of Supervisor (\*as applicable) PRINTED NAME & ROLE Date

[\*Required for students/residents/fellows]