The National Wisdom Tooth Study - Patient Consent Form

Patient's Full Name:	
NHS No.:	**Hospital or Dental Practice Name:**
Hospital No.:	
Patient's Date of Birth:	**Surgeon's Name:**

Consent for Data Collection and Processing - please add your initials to each box that you agree with	**Patient Initials**
I have read the information leaflet 'The National Wisdom Tooth Study - Information for Patients' (Version 12 - 08/12/20).	
I have had a chance to ask questions about the study and have had these answered satisfactorily.	
I agree to my personal details and health records that are related to my wisdom tooth treatment being collected by my operating surgeon.	
I agree to my data being stored by Saving Faces-The Facial Surgery Research Foundation for the purpose of carrying out research.	
I understand that my data will be stored and treated in a strictly confidential manner, in accordance with the Data Protection Act 2018 and the EU General Data Protection Regulation (GDPR) 2018.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
I understand that no publication that uses my data will identify me.	
I agree to my data being processed by individuals from Saving Faces-The Facial Surgery Research Foundation and Queen Mary University London, to produce the results needed to improve treatment.	
I agree to my data being shared, in a fully anonymised form which does not identify me, with other scientists or medical research organisations for use in ethically approved research studies	
I agree to complete a short web-based survey about my recovery, 1 month and 9 months after my operation.	
I also agree to Saving Faces-The Facial Surgery Research Foundation contacting me more than 9 months after this study for purposes related to this study.	
I consent to participate in this study.	

Email address:.. Mobile number: ....

We would prefer to contact you by email, but if you prefer to be contacted by telephone ☐ or postal address ☐ please let us know.

________________________________ ________________ ____________________________

Name of Patient Date Signature

________________________________ ________________ ____________________________

Name of Person taking consent Date Signature

Saving Faces
The Facial Surgery Research Foundation

If you do not want to sign the consent form, please can you let us know your reason(s) for not participating (Tick all that apply):

☐ I don't want to share my personal details
☐ I did not understand the study information
☐ I don't have the time to fill out any surveys
☐ I don't think the study sounds very useful
☐ I want to keep my privacy
☐ I'm concerned about information security
☐ I've been asked to complete too many surveys
☐ My questions about the study were not answered clearly
☐ It takes too much effort
☐ I'm not sure how my data will be used
☐ I would prefer not to say
☐ Other: ____

Please tick your Age Group:

☐ 15-19
☐ 20-29
☐ 30-39
☐ 40-49
☐ 50-59
☐ 60-69
☐ 70-79
☐ >80

Please tick your Gender:

☐ Male
☐ Female
☐ Other