

## Wisdom Tooth Surgery - Service Evaluation



<b>Patient's Full Name:</b>	
<b>NHS No.:</b>	
<b>Hospital No.:</b>	
<b>Patient's Date of Birth:</b>	
<b>Hospital or Dental Practice Name:</b>	
<b>Surgeon's Name:</b>	

<b>CONSENT FORM</b>	<b>Please tick one box for each section</b>	
	<b>Yes</b>	<b>No</b>
I have read and understood the information sheet dated 13/09/21 Version 1.5. I have had a chance to ask questions about the study and have had these answered satisfactorily.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from this clinic and the project team where it is relevant to my taking part in this project. I give permission for these individuals to have access to my records.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to my data being shared, in a form that does not identify me, with other scientists or medical research organisations who are undertaking further wisdom tooth studies.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to complete 2 or 3 web-based surveys about my operation and recovery.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in this study.	<input type="checkbox"/>	<input type="checkbox"/>

Please provide your email and mobile number so we can send you your surveys.

<b>Email address:</b>	
<b>Mobile number:</b>	

The surveys will be sent from [wisdomtoothsurvey@savingfaces.co.uk](mailto:wisdomtoothsurvey@savingfaces.co.uk) and [+44 7401 058522](tel:+447401058522). Please check your junk mail for the surveys.

\_\_\_\_\_

*Name of Patient*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*Name of Person taking consent*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Signature*

If you do not want to take part in this study, it would be extremely helpful if you could let us know why by completing the short form overleaf.

Tick the reason(s) why you do not want to take part in this study (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: \_\_\_\_\_

**Gender**

- Male
- Female
- Other

Age in years: \_\_\_\_\_

Please share any comments you have about the patient leaflet and/or consent form.